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ABSTRACT

A study explored the relationship between the content of educational programs in nursing and the quality of nursing care for older people, especially the extent to which nurses promote autonomy and independence. Activities included an analysis of curricula for pre- and postregistration nursing education programs in Britain, investigation of outcomes of a course on nursing elderly people in different care settings, and a national survey of facilities providing continuing care to older people. Curriculum analysis revealed content relating to most dimensions of autonomy and independence in most programs. Little evidence indicated older people's involvement in educational program development and delivery. The survey of nursing homes found a wide variation in the proportion of staff with a range of pre- and postregistration educational qualifications. Most nursing homes had little contact with nursing educational centers. Resident autonomy was positively associated with overall level of nurses' educational experience, proportion of qualified staff undertaking educational programs, and level of contact with nursing educational centers. Evaluation of the course on nursing elderly people suggested it was very successful in challenging stereotypical views of older people. Some course participants and managers were concerned about its relevance to their own practice setting. Nurse educators tended to focus on abstract concepts and theoretical ideas at the expense of practical applications. (Appendixes contain 211 references, instruments, and tables.) (YLB)

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PROMOTING AUTONOMY AND INDEPENDENCE AMONG OLDER PEOPLE: AN EVALUATION OF EDUCATIONAL PROGRAMMES IN NURSING

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PROMOTING AUTONOMY AND INDEPENDENCE AMONG OLDER PEOPLE: AN EVALUATION OF EDUCATIONAL PROGRAMMES IN NURSING

PREFACE

The English National Board is pleased to publish this report which has explored the relationship between the content of pre and post registration educational programmes and the outcomes of these in terms of the quality of care delivery. The report focussed particularly on the extent to which nurses promoted autonomy and independence in older people.

Through a variety of means the Board develops educational policy based on research evidence. The Board is concerned to evaluate the relationship between education and professional practice and through this to develop a cumulative body of knowledge of relevance to a multi professional audience. The conclusions emanating from this research evidence will be carefully considered in relation to the development of quality assurance methods. A further longitudinal study to promote the development of professional knowledge in this crucial area of care will be commissioned in 1997.

The report will be of interest to all those involved in the delivery of care of older people, practitioners, managers, commissioners of education and educationalists in nursing and other disciplines in health and social care.

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Chairman

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Chairman
Research and Development Group
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We would like to thank all the nurses, managers and nurse teachers who took the time to be interviewed or to complete our questionnaires - this study would not have been possible without them. Our special thanks go to the thirty nurses who agreed to be observed and to lay their practice open to scrutiny. The willingness of all who participated in the research to share their practice bodes well for the future of nursing.

Thanks to the older people who shared their experiences of receiving nursing care with us, and to Age Concern Sheffield who helped us to make contact.

Finally, thanks to our colleagues, friends and families who have supported us through the methodological challenges and ethical dilemmas posed by this research.

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IDENTIFICATION OF EDUCATIONAL NEEDS

DEVELOPMENT OF EDUCATIONAL PROGRAMMES FOR THE CARE OF OLDER PEOPLE

DEVELOPMENT OF LINKS BETWEEN EDUCATIONAL CENTRES AND PRACTICE ENVIRONMENTS

EVALUATION OF EDUCATIONAL PROGRAMMES

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SECTION 1

BACKGROUND INFORMATION

Context of the study

Promoting autonomy and independence for older people within nursing practice: a review of the literature

Approaches to the evaluation of continuing professional education: a methodological review

Chapter 1. Background to the Study

1.1 Introduction

In July 1994, the English National Board for Nursing Midwifery and Health Visiting (ENB) commissioned a multi-disciplinary research team at the University of Sheffield to undertake a two-year study to evaluate programmes of nurse education for older people. The research took place in the context of rapid change in the structure and delivery of health and social services to older people within both institutional and community settings. Simultaneously, reforms affecting pre- and post-registration nurse education have continued apace. In order to set the scene, this chapter describes some of the key events and initiatives which formed the political and professional backdrop to the study. An understanding of these events is crucial to an appreciation of the methodological and philosophical challenges faced by the research team. The chapter begins with an outline of the main demographic changes in relation to older people in the UK and the potential implications for gerontological nursing as a specialist area of practice.

1.2 An ageing population?

During recent years, the population of Europe has been steadily ageing. The long-term trends of lower birth rates, improvements in health status and rising longevity have combined to produce a steady growth in the proportion who are aged 60 years and over (OECD 1994). Moreover, these changes have not been consistent across different age groups, with the most rapid changes apparent among those aged 80 and over. Over the next twenty years, there will be a rapid increase in the ageing of ethnic minority groups, as those who migrated to Europe in the 1950s and 1960s reach old age (Blakemore and Boneham 1993). This is particularly significant as there is little published research on the needs and experiences of ethnic minority elders in the UK.

The shift in the age structure of the population has been accompanied by changes in the household situation of older people. As Sundstrom (1994) points out, the ways people live together have fundamental implications for patterns of giving and receiving care. The growth in solitary living, the decline in co-residence between generations and the increase in womens' employment outside the home are all having an impact on families' ability to provide informal networks of support for older people living independently.

It is important to recognise that ageing populations are a sign of economic and social success (Coleman et al. 1993, Walker 1996). Moreover, even among the very elderly, it is still only a minority that require institutional care (nineteen per cent of those aged 85 and over in the UK (Victor 1991)). Nonetheless, population ageing does present a challenge to service providers, partly because of the association between disability (including dementia) and advanced old age and partly because this change is accompanied by other socio-demographic changes (Walker 1996)

Most importantly, the trend towards smaller family size is resulting in a reduced 'caretaker pool' (Moroney 1976). Changes in family structure resulting from increases in geographical mobility and the impact of divorce are also influencing the availability of family support (Victor 1991, Coleman et al. 1993). Consequently, families are facing the prospect of caring for older relatives for longer and with fewer potential family members to help. Without adequate support, these caring relationships are likely to break down, resulting in increased demand for continuing care.

There are now indicators that the rate of increase in the numbers of very elderly people is slowing down. For example, in the ten years to 2006, the number of people living in the UK over 85 is expected to increase by approximately 100,000, representing one third of the growth in the previous ten years (DOH 1996). However, the numbers of 65-74 year olds will begin to increase more rapidly at the turn of the century.

1.3 The context of health and social care for older people: implications for nursing practice

The main users of the health and social care services are older people (Royal College of Physicians 1994); consequently changes in policy in relation to these services have a crucial influence on the care and well-being of this group. Across all European states, governments are demonstrating a preference for community care as opposed to hospital or residential care. However, Walker (1996) suggests that the increased emphasis on community care has done little to ameliorate the fragmentation of community care policies and service delivery within the UK between public, private and voluntary agencies and especially between the health and social services. In the UK, changes associated with the NHS and Community Care Act (DOH 1991) have shifted the responsibility and funding for 'social care' to local authority social services departments. Increases in means testing for such services are likely to result in a reduction in state-funded support for many elderly people (Arber and Evandrou 1993).

A further 'sea-change' in the way that health and social care services are delivered, is the current emphasis on user involvement in the planning and delivery of care, although the extent to which the 'rhetoric' of user involvement has translated into practice is unclear. Walker (1996) calls for a change in professional values and attitudes within the formal sector so that co-operation and partnership with users is regarded as a normal activity. However, a number of organisational principles and structures mitigate against user-participation in service planning and delivery, for example bureaucratic modes of organisation and models of training which encourage professionals to regard themselves as 'experts'.

Nursing Changes in the structure and delivery of health and social services for older people in the community, together with uncertainty about the future organisation of medical care for older people in hospital (Royal College of Physicians 1994) are redefining the nature of gerontological nursing (Waters and Wade 1996). While continuing care for older people has virtually disappeared from hospital wards and is now located firmly in the private sector, acute care is gradually being subsumed within general medicine. Simultaneously rehabilitation is emerging as a possible focus for specialist nursing practice.

The ideological shift towards the provision of health services in the community wherever possible, as evidenced in the implementation of government policies such as The Health of the Nation (DOH 1992) and the NHS and Community Care Act (1991), is placing new and increasing demands on nurses working in community settings. District nurses in particular are observing increasing dependency levels among patients in their care, not only as a result of earlier discharge from hospital but also as a consequence of innovative schemes such as Hospital at Home (Young 1991, Twinn 1996). With the introduction of the new GP Contract (DOH 1990), health visitors and practice nurses are increasingly involved in health promotion and screening activities with older people, often requiring new knowledge and skills. The Community Health movement is also suggesting new methods of working with communities, including older people, which encourage consumer participation in the identification of health need and the development of services to meet that need (see for example Drennan 1988).

An important consequence of these multifaceted changes is that the boundaries of gerontological nursing are increasingly blurred. This has considerable implications for education and training. Nolan (1994) both highlights the need for nursing to clarify its sphere of activity in relation to older people and promotes the notion of a generic worker. Central to his argument is the need to identify the 'shared core knowledge' necessary to provide effective care for older people (Hollingberry 1993). Nolan argues radically that joint training and learning at both pre-and post-registration level would create a new discipline capable of providing holistic care to older people and would begin to break down the inter-disciplinary barriers created by professional protectionism. There is also an urgent need to consider preparation for advanced practitioner status for those who have made a career choice to work with older people.

Questions about the appropriate educational preparation to provide nursing care for older people require a fundamental consideration of the nature of nursing and caring.
Nursing older people is frequently cited as an unattractive option and there have been suggestions that the continuing nursing needs of older people do not require the direct application of the skills of a qualified nurse (see for esample Pembrey 1986). Indeed many facilities within the private sector continue to experience difficulties in recruiting suitably qualified staff. Programmes of nurse education need to challenge commonly held stereotypes of ageing (Fielding 1986) and prepare practitioners to define the nursing role with older people who have differing needs.

The changes and challenges outlined so far require that new models of care for older people are continually developed and evaluated. Preparing nurses to meet such wide-ranging and changing needs presents an enormous challenge to nurse educators.

1.4 The changing face of nurse education

The last decade has witnessed a fundamental overhaul in the structure and organisation of both pre- and post-registration education for nursing practice. Radical reforms such as the introduction of diploma level courses leading to Registration (UKCC 1986), the integration of nursing and midwifery education into higher education and the introduction of mandatory continuing professional education (UKCC 1994) have all had an impact upon the way that education for the care of older people is organised. The Project 2000 reforms have been criticised for failing to identify the care of older people as a specialist branch within initial preparation programmes (RCN 1986). However, this has mirrored the gradual disappearance of specialist wards and units within the NHS, particularly in continuing care. The implications are that nurses working in a wide range of practice settings will need the skills to care effectively for older people and that consequently *all* programmes of preparation need to reflect the needs of older people.

The recent reform of post-registration nursing education (UKCC 1994) has introduced a requirement for mandatory professional updating linked with periodic registration for all registered nurses in the UK. The minimum study requirement of five days (or the equivalent) for all registered nurses during each three-year registration period has focused attention upon the identification of need in relation to continuing professional development and how these needs might be met. Furthermore, the shift into higher education provides opportunities to develop educational programmes which meet the specific needs of all disciplines engaged in the care of older people. Modularisation and the increasing availability of more flexible modes of learning have the potential to enable more practitioners to access programmes of continuing education.

Changes in funding arrangements have introduced market processes into the relationship between providers of health care and of nurse education. Consequently, the provision and content of educational programmes in nursing is increasingly driven by purchaser demand. The creation of education consortia as the purchasing agencies for non-medical education and training will act as a catalyst for change. The consortia, representing the NHS, the independent health care sector, social services departments and general practice will inevitably impact on the future structure, content and delivery of post-registration programmes. They will also influence pre-registration education. There will be increased calls for information on the effectiveness of educational provision as evidenced by changes in knowledge, attitudes and practice. As yet, there is a general absence of research-based evidence indicating changes in nursing practice consequent upon programme attendance (Peden et al. 1992). Indeed, a common criticism of much continuing professional education is that it has little effect on quality of care (Stein 1981). Future purchasing strategies may require such evidence in pursuit of value for money.

1.5 The research focus

The ENB required that the focus of this study should be the extent to which each educational programme prepares practitioners to promote patient/client independence and autonomy in the delivery of care to older people, including frail older people. The rationale for this focus lies within a body of research evidence demonstrating that 'routine' rather than individualised care predominates in a range of care settings providing nursing care to older people (see for example Norton et al. 1962, Wells 1980, Evers 1984, Barnes 1988, Reed 1989, Kitson 1991, Waters 1994, Nolan et al. 1995). Through discussion with the Board commissioners, it became apparent that the research needed to examine the extent to which programmes of nurse education could challenge stereotypes of ageing. A focus upon the dual concepts of autonomy and independence provides a mechanism for exploring nursing education's challenge to ageism.

According to Butler (1969) ageism is a process of systematic stereotyping of people on the basis of age. Wade (1996) suggests that such stereotyping allows younger people to see older people as different:

> *thus they subtly cease to identify with their elders as human beings (p30)*

Wade (1996) differentiates three types of ageism. *Compassionate ageism* emphasises the problems of old age which, Wade suggests, promotes an image of older people as weak, dependent and burdensome. *Conflictual ageism* attempts to limit the resources available to older people who are seen as 'avaricious consumers of health care'(p31), who conversely contribute little to society. *Medical ageism* perpetuates practices whereby older people do not benefit from advanced technology and medical interventions (Grimley Evans 1994). Wade argues that nursing can influence such stereotypes by developing gerontological nursing courses that help to change attitudes, through creative teaching and learning styles. This assertion is supported by research (Snape 1986, Dellasega and Curriero 1991). However, there is also empirical evidence to suggest that programmes of nurse education, rather than improving attitudes to older people, can have the converse effect (Haight et al 1994, Slevin 1991). It is therefore imperative to identify features of educational programmes which successfully challenge stereotypical views and equip nurses with the skills to promote an individualised approach to the care of older people.

1.6 Aims and research questions

The overall aim of this two-year project, as specified by the ENB, was to determine the extent to which pre- and post-registration educational programmes in nursing in England prepare practitioners to promote patient/client autonomy in the provision of care to older people, including frail older people. The study specifically aimed to address the following research questions:

1) what are the effects for older people and for health care personnel of nursing interventions aimed at promoting independence and autonomy?

2) what is the range in course philosophy, design, content and teaching and assessment strategies in relation to the promotion of independence and autonomy within pre-and post-registration educational programmes?

3) does the variation in educational preparation among staff in continuing care settings impact upon the quality of life of residents within those care settings?

4) what are the effects of pre- and post-registration educational programmes on the knowledge, attitudes and practice of nurses working in a range of hospital and community practice settings?

5) what are the perceptions of course members, their colleagues and course teachers in relation to the effects of specified educational programmes on nursing knowledge, attitudes and practice?

1.7 Structure of the report

The research team designed a three phase study, building upon reviews of relevant literature, to provide discrete answers to each research question (Figure 1.1). The report is organised in three sections. The research process and findings in relation to each phase are set out as shown below. Due to a number of practical difficulties and constraints, it was not possible to execute the original research design as laid out in the project proposal. These difficulties are fully discussed in an attempt both to inform other researchers in the field, and to contribute to the debate on approaches to the evaluation of education.

Section 1 Background: introduction and reviews of relevant literature (chapters 1 - 3)

Chapter 2: explores the consequences for older people of interventions aimed at promoting autonomy and independence based upon a review of the literature;

Chapter 3: discusses methodological approaches to the evaluation of continuing professional education;

Section 2 Empirical work: methods and findings (chapters 4 - 8)

Chapter 4: takes the form of a critical analysis of the philosophy, theoretical framework, design and content of a representative sample of pre-and post-registration educational programmes relating to the needs of older people (Phase I of the study);

Chapter 5: provides a description of the relationship between the qualifications and educational preparation of nursing staff and client/patient autonomy in continuing care settings (Phase II of the study);

Chapter 6: discusses the methodological challenges experienced in attempting to set up a randomised controlled trial to evaluate a short programme of continuing professional education for the care of older people - the ENB Course 941(Phase III);

Chapter 7: outlines the methods used to evaluate the ENB Course 941 once the RCT methodology had been found to be inappropriate. This chapter also describes the development of two instruments, a self-completion questionnaire and an observational tool, to assess the extent to which nurses promote autonomy and independence in their interactions with older people in a range of care settings (Phase III of the study);

Chapter 8: provides information on the outcomes of selected educational programmes in terms of knowledge, attitudes and behaviour of course members in a range of practice settings. Information is also presented on the perceptions of course members, their colleagues and course teachers on whether educational programmes make a discernible difference to the extent to which nurses promote client/patient autonomy in practice (Phase III);

Section 3 Discussion, critique and developmental implications (chapters 9 - 10)

Chapter 9: discusses and synthesises the findings from each phase of the study and includes a methodological critique of the overall design;

Chapter 10: identifies implications for the future development of educational programmes for the nursing care of older people and for further research in this field.

Figure 1.1 Overview of study design

PHASE I

National survey of programme leaders for a random sample of pre- and post-registration educational programmes in nursing in England, to identify aspects of the curriculum which relate to the promotion of independence and autonomy among older clients/patients
(n = 77)

Content analysis of a random sample of curriculum documents
(n = 59)

PHASE II

Survey of nursing homes in three Health Regions to investigate the relationship between the educational preparation of staff and resident/patient autonomy and choice
(n = 660)

PHASE III

Quasi - experimental design to determine the effects of selected educational programmes on the knowledge and attitudes (n = 38) and observed practice (n = 30) of nurses in a range of care settings

Semi-structured interviews with course members, colleagues and course teachers following post-test data collection
(n = 43)

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Chapter 2. Promoting autonomy and independence for older people within nursing practice: a review of the literature

2.1 Introduction

The principles of promoting autonomy and independence underpin many of the guidelines for improving the quality of nursing care for older people in a range of settings (Wade and Sawyer 1981, RCN 1987) and are in line with wider developments in health care such as the NHS Patients' Charter (DOH 1992). However, these concepts require careful definition if the nursing practices which might promote autonomy and independence are to be identified. This review explores definitions of autonomy and independence in literature generated from a range of disciplines and examines the evidence in relation to nursing interventions aimed at promoting the autonomy and independence of older people. A summary of the methods used to identify and review the literature is included as Appendix I. For the purposes of this chapter, key themes and issues which emerged from this process are presented and discussed.

The review outlines some characteristics of autonomy and independence before considering why these concepts are relevant to the nursing care of older people. Factors which appear to be associated with the promotion of patient/client autonomy and independence within the literature are then explored. The review concludes by identifying some general principles for care-giving, appropriate to a range of settings, which may enable nurses to promote the autonomy and, where appropriate, the independence of older people in their care. From these broad principles, practice dimensions or indicators are derived to form the basis of instrumentation for the research.

The main purpose of the review was to explore the rationale for focusing upon the autonomy and independence of older people as indicators of quality of care and to identify dimensions of these concepts which could provide a basis for the development of instrumentation within the study. A deeper consideration of the influences of an older person's age, ethnicity, gender, or level of disability on the need for autonomy was beyond the scope of the investigation. While the research team are in no way suggesting that older people are an homogeneous group, the review was limited for pragmatic reasons in order to identify some general principles of care-giving which could be applied in a range of care settings and to a wide range of older people.

2 Characteristics of autonomy, independence and dependence.

Any study of autonomy in old age requires a conceptual definition that is broadly applicable to a range of older people yet amenable to empirical validation (Horowitz et al 1991). Unfortunately, definitional precision is rarely encountered within the literature and 'autonomy' remains a widely used but loosely defined concept (Beauchamp and Childress 1989). One definition which appears to have particular relevance within the context of the nurse-patient/client relationship is formulated by Horowitz et al (1991), who suggest that autonomy is:

> *the exercise of self-determined, goal-oriented behaviour that is or can be potentially threatened or inhibited by a variety of circumstances, real or symbolic, intrinsic or external to the person* (Horowitz et al. 1991 p.23).

Atkinson (1991) and Macmillan (1986) agree that autonomy is concerned with self determination and the ability to make choices. Hertz (1993) suggests three defining attributes: voluntariness, individuality and self-direction. These denotations suggest that personal autonomy is both multi-dimensional and context dependent (Collopy 1988). Sciegaj and Capitman for example (1994), propose that all individual autonomy is embedded in particular relationships and circumstances.

Collopy et al. (1991) make the important distinction between decisional autonomy (decision making) and executional autonomy (implementing decisions). The risk for nursing practice is that decisional autonomy can easily be denied when executional autonomy is diminished or lost. A second important distinction is between short and long-term autonomy (Lindley 1988, Collopy et al. 1991, Brown 1995). For example, it may be considered ethical to compromise an individual's autonomy in the short-term in order to promote their long-term autonomy. An example would be the administration of medication without a patient's consent if it were thought that the medication would restore the capacity for self-determination in the future.

Several authors suggest that, in order to make an autonomous decision an individual must be capable of rational thought and self governance (for example Hogstel and Gaul 1991). Again there is a challenge for nursing practice to recognise when an individual is capable of making autonomous decisions. Moreover, the need to balance the promotion of autonomy and independence with the need to minimise risk constitutes an important dilemma. Beauchamp and Childress (1989) go some way towards a resolution in suggesting that:

> *our decisions are never ideal: they can never be fully informed, voluntary or autonomous; but that does not mean they are not* ***adequately*** *informed, free or autonomous* (our emphasis) (Beauchamp and Childress 1989)

Independence is frequently used as a synonym for autonomy. However, it is perhaps more appropriately viewed as one dimension of, or a factor contributing to personal autonomy. Independence is most frequently associated with an individual's level of physical functioning and ability to perform the activities-of-daily-living unaided. Indeed, many older people equate their own level of health or well-being with their level of functional ability (McLymont et al 1991). It would therefore seem appropriate for nurses to aim their interventions at maintaining or recovering the older person's optimal level of physical functioning. It is of course possible that the need to promote autonomy may conflict with the need to promote independence: people requiring care may ***choose*** to become more dependent. Autonomy and independence should therefore be viewed as goals of care which are inter-related but not synonymous.

In an attempt to further our understanding of the concept of independence we considered the notion of dependency, which has been described both as a continuum (Hockey and James 1993) and a relationship (Phillips 1986). The relationship usually implies a degree of inequality between the dependent and the depended upon (Bond and Bond 1987) and is characterised by loss of control on the one part and loss of personal freedom on the other. Walker (1982) identifies four dimensions: life-cycle dependency, physical and psychological dependency, political dependency and economic dependency. Older people requiring nursing care are frequently dependent in some or all these dimensions. However, this does not imply that they cannot make autonomous decisions in these areas.

2.3 Autonomy and independence: why are these important concepts for nursing?

Within the context of the 'new nursing' (Pearson et al 1988, Salvage 1992), enabling a patient or client to be as autonomous and independent as possible is seen as an integral part of nursing's therapeutic function. Clay for example suggests that a caring environment is one offering individuals the opportunity to develop their potential and the freedom to choose their own course of action (Clay 1986). As nursing moves away from a medical model of care towards a bio-pyschosocial model, the patient's role is being re-defined. Patients are now expected to take an active part in their care and to divulge private information to enable the nurse to create an individual care plan which recognises all the patient's needs. As a further consequence, patients are now held to be more responsible for their own health (Salvage 1992, Trnobranski 1994, May 1995). However, a number of commentators have questioned whether patients actually welcome this 'new role' and the 'new nursing' it involves (Waterworth and Luker 1990, May 1995).

The current emphasis upon developing individualised, patient-centred nursing practice is in line with wider developments in health care. The promotion of consumerism within the NHS has introduced the notion of choice in health care, at least in theory (DOH 1991, 1993). Within the context of the Patient's Charter for example (DOH 1992), older people in receipt of health services are afforded the right to certain standards of care. Of particular relevance to the current discussion are the following standards:

- the right to be given a clear explanation of any treatment proposed, including any risks and any alternatives;

- respect for privacy, dignity and religious and cultural beliefs;

- arrangements to ensure that everyone, including people with special needs, can use services;

- that information is supplied to relatives and friends (DOH 1992).

There is evidence to suggest that many of the principles embodied within the Patient's Charter are of particular importance to older people. For example the notion that, for older people, a sense of being competent, autonomous and appreciated is basic to the experience of a good life finds support in a number of empirical studies, (Higgs et al 1992, Nystrom and Segesten 1994, Oleson et al 1994). A study of nursing-home residents' views of what constituted a healthy life identified three main conditions: acceptable function in daily life, positive self-esteem (related to a present experience of independence and autonomy) and experience of peace of mind (Nystrom and Andersson-Segesten 1990). Another study in a similar setting (Oleson et al 1994) used a phenomenological approach to compare nurses' and residents' perceptions of factors contributing to a good quality of life for older people. Analysis of semi-structured interviews with nine nurses and ten residents from three nursing homes in south-west England identified several themes common to both respondent groups. These were: *individuality* (concerned with the unique characteristics of residents), *connectedness* (referring to creating and maintaining relationships), *professionalism* and *physical functioning*. However, there were different emphases in the nurses' and the residents' responses - in particular, the residents described their quality of life in terms of how successfully they were able to create meaning in their lives by coping with and adapting to the age-related changes of increased dependence - a factor which was not described by the nurses. The authors conclude that the difference in perceptions between residents and staff may result in residents' needs not being met. Higgs et al. (1992) investigated the effects of institutionalisation for elderly patients on long-stay wards (n=291). Structured interviews focused upon the degree of choice which patients felt they had in relation to daily activities. Eighty per cent of those interviewed expressed satisfaction with their own level of personal autonomy. However, elderly patients may be more likely to express satisfaction than younger people for reasons of social desirability and fear of reprisals (Breemhaar et al 1990), and this should be taken into account. Perhaps a more significant finding of Higgs' study was that 46% of those interviewed considered that loss of independence was the worst thing about being admitted to a long-term care facility.

McWilliam et al. (1994) highlight the contribution of personal characteristics to the achievement of personal autonomy. In a study of patients and carers (n=21 and n=139 respectively), it was found that patients with a positive 'mindset' did not feel that their autonomy was threatened, even when cared for in a paternalistic manner. This suggests the need to make an assessment of an individual's personality type in considering how best to promote their autonomy and independence.

Despite the assertion by many older people themselves that autonomy and independence are important to a good quality of life, nurses working in institutional settings frequently observe passivity and dependence among older people in their care (Barder et al 1994). One theory to explain this apparent dissonance is the 'learned helplessness' theory (Seligman 1975), which proposes that a condition of helplessness develops when individuals experience uncontrollable life events. There is evidence to suggest that nurses themselves can contribute to dependent behaviours in older people (Baltes et al 1983, Miller 1985, Waters 1994). Avorn and Langer (1982) for example present evidence to suggest that nurses inadvertently cause dependence in elderly people by performing more helping activities than physically required. The message conveyed to patients is that they are themselves incapable of performing the task.

There is some evidence to suggest that the desire for control over health care decisions is lower among elderly people than among younger adults (LeSage et al 1989). However, Rodin (1986) asserts that the needs of older people for self-determination may be fulfilled by allowing them to choose *not* to exercise control. Kenny (1990) highlights the significance of the social exchange theory of ageing in relation to patient autonomy and participation which may explain why older people are more reluctant to collaborate in decisions about their care (Dowd 1975, Tryban and Nall 1980). This suggests a possible educational role for nurses in encouraging older people to recognise the contribution which they make both within relationships and within societal groups.

2.4 How can nurses promote patient/client autonomy and independence?

The most appropriate nursing actions to enable an older patient or client to be as autonomous and independent as possible will to some extent be context dependent (Collopy 1988): what is appropriate in an acute hospital ward may differ from what is appropriate in a continuing care setting, or in an older person's home. Moreover, the vagueness of concepts such as autonomy and independence within the literature hampers attempts at operationalisation. Even where broad concepts such as autonomy have been focused into more precise dimensions, for example maintaining individuality and respecting dignity (Booth 1985, Willcocks et al 1987), these dimensions remain at the abstract level and require the identification of more objective practice indicators in order to be measureable (Gilloran et al 1994). For example, one indicator of attempts to promote patient autonomy might be seen in the degree of choice offered to patients in relation to various aspects of care such as having a bath, eating meals and going to the toilet. The provision of information to patients before and throughout an activity might be seen as another objective indicator of attempts to promote self-determination.

In reviewing empirical studies which have attempted to measure the quality of nursing care for older people in a range of care settings, a number of these more objective indicators were found to recur. These included:

- implementation of systems of care delivery which promote comprehensive individualised assessment and multi-disciplinary care planning
- attempts to encourage patients/clients to participate in decisions about their care
- patterns of communication which avoid exerting power and control over patients/clients
- attempts to modify the environment to promote independence and minimise risk

The remainder of this chapter will focus upon these dimensions in more detail.

2.5 Systems of care delivery which promote comprehensive individualised assessment

There is growing evidence that the way in which nurses organise their care can affect patient outcomes relating to autonomy and independence (Naqvi and Wilson 1988, Faucett et al. 1990). In particular, an individualised approach to the delivery of nursing care has been associated with the maintenance of independence for older patients remaining in hospital for more than one month (Miller 1985). In an observational study of nurse-patient interaction on wards practicing primary, team and functional nursing, Thomas (1994) found that regardless of staff grade, nursing staff in wards practicing primary nursing gave patients more choice, offered more explanations about their care and spent more time seeking feedback from patients.

Wade (1983) identifies four different models of long-term care based upon interviews with older people and care staff in private nursing homes and hospital geriatric units. These models, termed supportive, protective, controlled and restrained, were derived from a consideration of two dimensions of care: person-centred *versus* task-centered and open *versus* closed (Figure 2.1). The authors advocate the supportive model of care for older people in continuing care settings, characterised by consultation and involvement of older people in the care regime, the involvement of visitors including relatives, volunteers and children and breaking down barriers between the institution and the community.

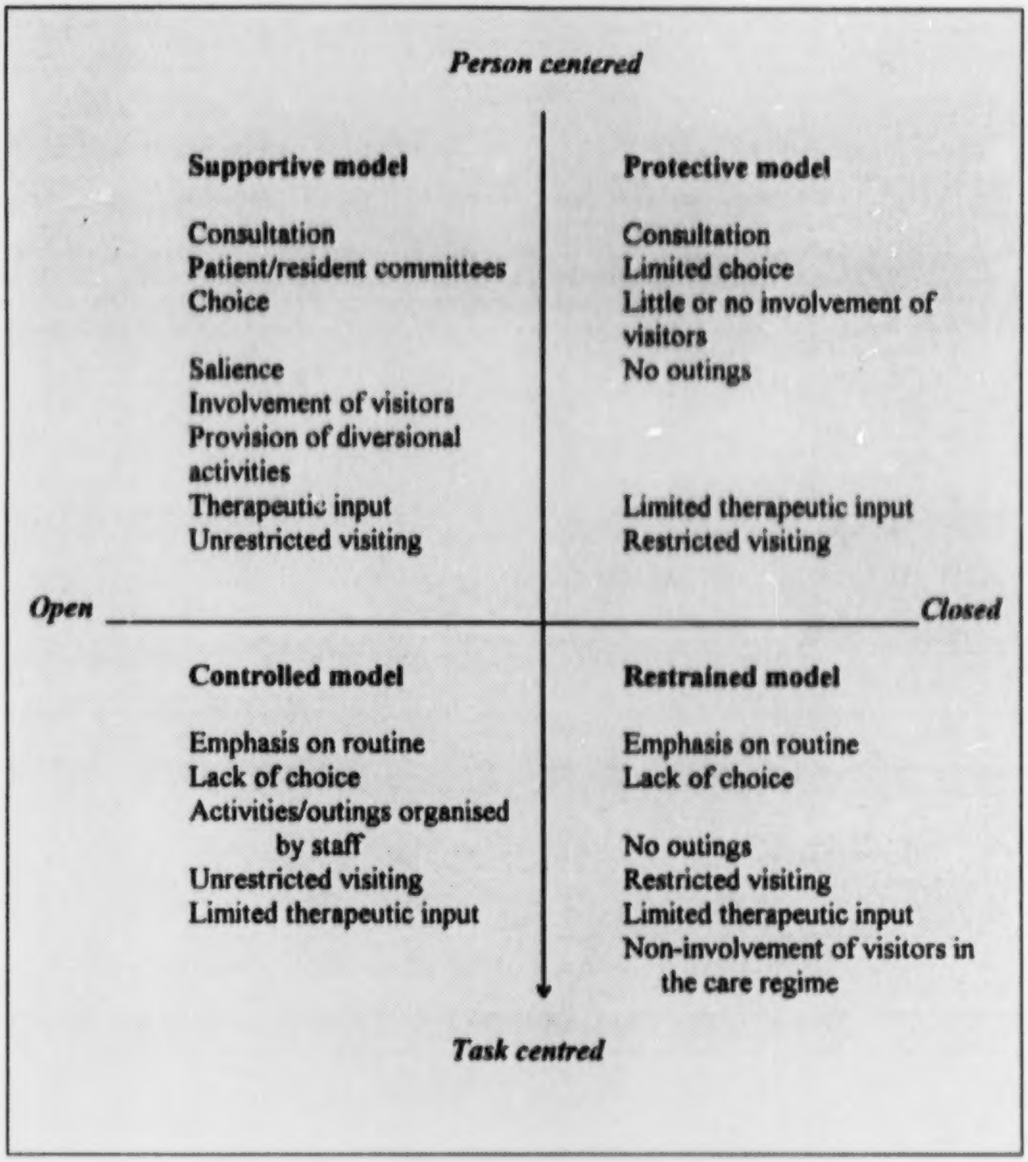
A number of authors have described how use of a nursing model has helped them to work collaboratively with patients and their families. Bowles et al. (1995) adapted aspects of Neuman's model and Orem's model to develop the assessment documentation within a rehabilitation unit for older people, identifying improved communication with families as a result. Kenny (1990) advocates the use of King's model of nursing which advocates greater patient participation through mutual goal setting, keener awareness of the patient's perceptions and the establishment of an equal, reciprocal and collaborative relationship between nurse and client. However, these findings are based largely upon opinion and personal experience and should be interpreted with caution. Certainly any relationship between the use of a particular nursing model and the promotion of patient autonomy and independence has yet to be established empirically.

Mention should be made of the potential for effective teamwork on the part of the multi-disciplinary team to promote patient autonomy and independence. Nurse-led team care, where a named nurse coordinates the care of individual patients, has been evaluated in a range of settings providing care for older people (Pearson et al 1988, Davies 1994, Griffiths and Evans 1995). Collectively, the findings suggest that an individual patient's needs are more likely to be taken into account within this particular model of care delivery. Conversely, there is some evidence to suggest that where there are conflicting professional perspectives on an individual patient's needs and appropriate interventions, this may act as a barrier to patient autonomy by limiting patient participation and reducing the continuity of care (Webb and Hobdell 1980, Evers 1981, Reed 1994).

2.6 Attempts to encourage patients/clients to participate in decisions about their care

During the past decade, there has been an increasing emphasis on patient involvement in care (Trnobranski 1994). This accords with the current political emphasis on patients as consumers of health care (DOH 1992), and finds a rationale in a body of research evidence to suggest that active patient participation leads to improved patient outcomes and better patient adjustment (Horsley 1983, Wilson-Barnett and Fordham 1983).

Figure 2.1. Typology of models of care delivery (Wade 1983)


Person centered
Supportive model
Consultation
Patient/resident committees
Choice
Salience
Involvement of visitors
Provision of diversional activities
Therapeutic input
Unrestricted visiting
Protective model
Consultation
Limited choice
Little or no involvement of visitors
No outings
Limited therapeutic input
Restricted visiting
Open
Closed
Controlled model
Emphasis on routine
Lack of choice
Activities/outings organised by staff
Unrestricted visiting
Limited therapeutic input
Restrained model
Emphasis on routine
Lack of choice
No outings
Restricted visiting
Limited therapeutic input
Non-involvement of visitors in the care regime
Task centred

Like autonomy, the notion of patient participation involves several dimensions including collaboration, partnership and involvement (Brearley 1990). Brownlea (1987) provides the following definition:

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> *participation means getting involved or being allowed to become involved in a decision-making process, the delivery of a service, the evaluation of a service or even simply to become one of a number of people consulted on an issue or matter* (Brownlea 1987 p.605).

Brearley (1990) highlights the important contribution of informed consent, patient teaching and the provision of relevant information. However, the relationship between patient participation and patient autonomy is not clear cut. In particular, the issue of choice in relation to participation requires further study as the limited empirical work in this areas is largely exploratory and inconclusive.

Waterworth and Luker (1990) report a qualitative study to identify how patients perceived being involved in decisions about their care. Informal interviews were carried out with a convenience sample of twelve patients on three medical wards within one hospital. Unfortunately, the age range of the patients interviewed is not stated. One major theme emerged from the data, that of 'toeing the line'. The data suggested that some patients are more concerned about 'doing what is right' and about pleasing the nurse than about participating in decisions concerning care. The authors contend that, by adopting practices which encourage patient involvement, nurses may unwittingly be coercing patients to comply.

The need to ensure that attempts to involve patients in decision-making are based upon an individualised assessment of need is self-evident. On the whole, research into the area of patient participation has failed to take into account factors such as educational background, character, race, gender, age and diagnosis - factors which may have an effect on whether a patient wishes to be involved.

It has been suggested that involvement in decision-making assumes rationality and capability (Macmillan 1994). Biley (1992) explored the relationship between capability and autonomy in interviews with eight surgical patients ranging in age from 21 to 75 years. Thematic analysis identified three types of situation that affect patient choice and participation in decision making about their nursing care. These were 'If

I'm well enough', 'If I know enough' and 'If I can'. Patients were more concerned with less technical information such as medication and activities of daily living when very ill and there was some evidence that when patients were acutely ill, they were willing to relinquish control to the nurse. Although this study involved a small sample and categories did not reach saturation (Glaser and Strauss 1967), the report provides some indication that patients' desire to participate in decisions about their care will be affected by several factors, not all of which are within the nurse's control. Biley's study also suggests that patients can benefit from being in control of what might amount to only a small aspect of their care in an environment where they essentially lack control.

An action research project reported by Sheppard (1994) adds weight to the importance of involving patients in their care and identifies specific strategies through which patients might be encouraged to participate. Interviews with older people following discharge identified three necessary changes: the provision of information to patients, continuity of care and encouraging patients to be critical. Subsequent interventions included the establishment of a Patient Forum, adoption of a no-uniform policy and the development of an information video to be shown to patients and new staff.

2.7 Patterns of communication which avoid exerting power and control over patients/clients

Some nursing research studies have usefully applied the methods and concepts of socio-linguistics to the study of interactions between nurses and older patients. Findings suggest that such interaction is frequently short, initiated by the nurse and largely task-orientated (Wells 1980, Seers 1986, Armstrong Esther et al 1994). Moreover, in a wide-ranging review, Lanceley (1985) highlights the potential for nurses to use controlling language when caring for older people and argues that relations between nurses and older patients can be characterised by opposition between those who have power and those who are subordinate to that power. Use of the patient's Christian name, pluralisation of the patient as 'we', use of 'must' and 'ought' and reference to the patient as a passive object are highlighted as examples of controlling or depersonalising language. In support of this position, Kenny (1990) suggests that verbal interaction is:

> *a major avenue for social control on a large scale and inter-personal dominance on a small scale* (Kenny 1990 p.571)

However, the use of language may also be a mechanism for attempting to protect an older person's human rights (Block and Simnott 1979) for example by ensuring that language used in care delivery is acceptable to the older person and respectful of their cultural beliefs and practices (Phillips et al 1990).

Based upon an observational study, Thomas (1994) identified 'categories of talk' in an attempt to measure the quality of interaction between nurses and elderly patients. Thomas suggests that categories such as giving patient choice, offering explanations and encouraging feedback indicate that the nurse views the patient as an individual with inter-related needs, and that these strategies can be facilitated by a one-to-one relationship between nurse and patient. Davies (1992) also perceived a relationship between the use of verbal strategies such as offering choice, explanation of actions and eliciting feedback and the success (or otherwise) of a verbal exchange for older patients in a continuing care unit. This study used an exploratory observational technique with a small sample (twelve nurses and eight patients) in one setting. The findings are therefore tentative but would merit further investigation.

Marck (1990) identifies 'therapeutic reciprocity' as one approach to evaluating the nature of nurse/patient interaction. It is argued that therapeutic reciprocity is based upon a genuine exchange of feelings, thoughts and experiences which lead to the creation of shared meaning and understanding. In practice, this could involve a nurse sharing information about her life outside work, or letting the patient know that s/he (the nurse) has benefited from the relationship with the patient. Nolan and Grant (1993) highlight the difficulties of establishing therapeutic reciprocity with continuing care patients who may have limited abilities to share thoughts and feelings and they suggest that these difficulties contribute to the tendency to develop custodial relationships in such settings. Lack of reciprocity is also highlighted as a factor contributing to feelings of inferiority among nursing home residents (Nystrom and Segelsten 1994). Davies (1992) identified 'giving of self' as one category of interaction that appeared to be associated with successful exchanges between nurses and older patients in receipt of continuing care. The potential for nurse education to enable nurses to establish relationships with older people that incorporate a degree of reciprocity has yet to be established.

2.8 Attempts to modify the environment to promote autonomy and independence and minimise risk

Negative characteristics of the total institution first identified by Goffman (1961), which strip patients of their identity and limit their sense of control have since been reported in a range of studies investigating the quality of nursing care for older people (Miller and Gwynne 1972, Evers 1984, Baker 1978, Reed 1994, Waters 1994). Any attempts to 'deinstitutionalise' the environment through efforts to recognise and meet individual needs could be seen as promoting personal autonomy. It has been suggested for example that wearing one's own clothing is an important contributor, not only to the older person's self-respect and dignity but also to the attitudes of those providing care by encouraging them to view the person as an individual (Meredith 1987, Burgess et al 1988). Wade (1983) highlighted organisational barriers to individualised care and personal autonomy in nursing home; for example, difficulties in offering residents a choice about what time they got out of bed in the morning were related to the fixed time at which breakfast was served, a point also noted by Barnes (1988). The removal of such constraints may require negotiation at a number of levels within an organisation.

Safety is another important factor when considering measures to promote autonomy and independence for older people. Nurses working with older people are frequently called upon to weigh an individual's rights for self-determination against possible risks to personal safety and such deliberations may lead to decisions which limit autonomy and independence if the risks appear too great (Nystrom and Segesten 1994). Certainly there is little empirical evidence to demonstrate how nurses balance the need to promote patient autonomy and independence with the need to minimise risk.

Norman (1980) argues that in extreme cases, the need to minimise risk can limit the therapeutic value of an institution. Indeed, there is some empirical evidence to support this notion. Bowling and Grant (1992) report a randomised controlled trial to compare patient outcomes for patients admitted to Health Authority funded nursing homes and long stay wards in one Inner London Authority. The findings suggest that although accident rates were higher in the nursing homes, the quality of life was better. In discussing the implications of this study, the authors question whether much of what is described as 'risk' does in fact pose a serious risk to health or whether it relates more to the feelings or inconvenience of the carer. Again the importance of an individualised approach is emphasised. Bowling and Grant (1988) propose that if the outcome of greater freedom and flexibility in nursing homes is an increased degree of risk, then managers and staff of these institutions have a responsibility to ensure that all possible preventive measures have been taken. Askham et al. (1990) reviewed the literature relating to the prevention of falls and identified a number of preventive measures in relation to the environment. These include: identifying and observing high risk individuals, ensuring a barrier-free environment, providing beds with adjustable heights and chairs with correct backs and arm rests, ensuring non-slippery floors, and the provision of hand-rails. Given the ethical dilemmas posed by the need to balance maximum patient autonomy with minimum risk, the importance of ensuring that all possible preventive measures have been implemented is clear.

At one extreme, the denial of patient autonomy is epitomised by the use of physical restraint. McHutchion and Morse (1989) suggest that while nurses empathise with the restrained patient, they often see no alternative. Organisational policies may emphasise the reduction of risk in order to avoid litigation, posing a dilemma for health care professionals (McHutchion and Morse 1986, Yorker 1988, Conely and Campbell 1991, Archea et al 1993). Resolution of the potential threat to autonomy and independence posed by the notion of 'risk' appears to require an attitude shift on the part of these organisations as much as behaviour change on the part of individual nurses. There is also a need for nurses to have the opportunity to discuss their views on patient restraint and to consider possible alternatives. Stillwell for example found that 63% of a sample of 500 nurses had received no instruction on the use of physical restraint on geriatric wards (Stilwell 1991). A recent joint publication of the *Royal College of Nursing* and the *British Medical Association* provides useful guidance on issues relating to consent and restraint when caring for older people (BMA 1995). However, there is a need for empirical work to investigate nurses' decision-making processes in relation to the balance between promoting patient/client autonomy and maintaining patient/client safety.

2.9 Summary and critique

Because of the varied dimensions of the topic, a wide range of research approaches have been used to investigate both the process and outcome of nursing interventions aimed at promoting autonomy and independence for the older client/patient. Given these varied approaches, and the range of settings in which research has been conducted, it is difficult to compare and contrast individual studies in order to generate clear indicators for nursing practice. In effect, this body of research literature indicates rather more of 'what nurses could try' rather than 'what nurses should do' (Hunt 1981). In particular, there is little information to inform decisions related to the balance between minimising risk and promoting patient/client autonomy. However, this is essentially an ethical debate which can perhaps only be informed to a limited extent by empirical work. In justifying and defending standards of care that meet basic humanitarian principles (Ebrahim et al 1994), nurses frequently need to rely upon non-empirical knowledge and understanding (Carper 1978).

Most research related to the topic has been carried out in long-term care settings and it may not always be appropriate to extrapolate from one care-setting to another. Empirical evidence which identifies factors associated with the quality of care for patients in acute, rehabilitation and community settings (other than nursing homes) is limited. Moreover research which has sought the views of older people themselves has focused upon those without a significant degree of cognitive impairment. While it is likely that the principles of care-giving which have emerged from this review are as

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relevant to working with older people who are less 'active', the means of achieving them requires special consideration. There is some evidence, for example, that innovative approaches to user involvement can ensure that the views of very frail older people contribute to service development (Barnes and Walker 1996). However, there is an obvious need for further research, particularly in relation to identifying the views of service users themselves.

In spite of these methodological limitations, the body of literature provided pointers for nursing practice within the current project. A consistent theme is the need to ensure that nursing care is tailored to individual needs if patients and clients are to achieve optimal levels of autonomy and independence. Individualised assessment and care planning appear to underpin many of the strategies associated with the promotion of autonomy, independence and high quality care within the literature. Systems for care delivery which support patient-centred practice such as primary nursing and nurse-led team care have also been associated with higher levels of self-determination and patient satisfaction, although the evidence to date has emerged from a series of small-scale studies.

The evidence in relation to interpersonal strategies which encourage patient choice and participation in decision-making is more persuasive. In particular it appears that even the ability to make quite small decisions about day-to-day activities can make a significant impact on an older person's sense of control. A wealth of research conducted in a wide range of care settings has demonstrated the importance of adequate information in promoting patient recovery and this should form a fundamental principle of care delivery. The consequences of eliciting feedback from a patient in relation to care given is less well documented but some evidence suggests that identifying the patient/client's perspective should be a basic principle of care. In particular, there is evidence to suggest that there is often a disparity between nurses' perceptions and the perceptions of older people themselves in relation to priorities for care-giving.

Other strategies which recognise the patient as a person with individual needs include identifying the extent to which a patient or client wishes to be involved in care planning and delivery, demonstrating reciprocity within the nurse-patient relationship and attempting wherever possible to promote patients' privacy and dignity. However, nurses should also be alert to the socialising effects of institutions and organisations which may influence patients' expectations of their relationships with health-care professionals. Organisational barriers to change, such as fixed meal-times within an institution or a lack of aids and equipment, may also act as a constraint upon patient choice and autonomy. Perhaps one of the most effective actions that nurses could take to promote greater autonomy and independence for older patients and clients would be to campaign for greater flexibility in these areas.

A note of caution is sounded in a useful review of the literature on patient empowerment (Elliott and Turrell 1996). While supporting the general ideal, the authors highlight several important tensions for nurses attempting to empower patients. These include advocating 'active' patients while allowing for patient individuality, acknowledging patients' right to decide but accepting the practical constraints on their freedom to choose, ensuring informed choice without creating information overload and providing individualised care without invading the patient's privacy. It was important for the research team to acknowledge and allow for these tensions in attempting to identify the dimensions of nursing practice which would provide a focus for this study.

This review suggests a need for further research to establish patient and client outcomes in relation to specific nursing interventions aimed at promoting autonomy and independence. However, in the absence of firm predictive evidence, we would argue that there is sufficient descriptive research to suggest that the principles identified within this review should provide a basis for nurse education and practice at the present time. These are:

- offering choice in relation to day-to-day activities
- giving information about care

- eliciting feedback on care given
- encouraging participation in care planning
- promoting independence in the activities of daily living
- facilitating privacy and dignity
- demonstrating reciprocity

These dimensions informed the development of instrumentation for Phases I and III of the study.

Chapter 3. Approaches to the evaluation of continuing professional education: a methodological review

3.1. Introduction

The need to determine whether education for the care of older people has an impact on practice, highlighted in the introduction to this report, suggests that evaluation needs to include some form of outcome measurement. Continuing professional education in nursing has been shown to have several outcomes including: improved care planning (Hughes 1990), the informal exchange of ideas between participants (Rogers and Lawrence 1987, Whiteley 1989), greater assertiveness and autonomy (Lathlean et al. 1986, Hughes 1990, Turner 1991, Williams 1991) and personal and professional growth (Lathlean et al. 1986, Whiteley 1989). Within a nursing context, the evaluation of educational programmes has traditionally focused on programme content, teaching strategies, learning experiences in the clinical area, and personal and professional development (Conners 1989), variables more commonly associated with educational processes rather than products or outcomes. However, recent literature suggests a limited but steady trend towards evaluation of the effects of continuing education on practice (Heick 1981, Bignell and Crotty 1988, Harrison and Novak 1988, Hughes 1990, Dunn et al. 1992, Cronin-Stubbs et al. 1992, Brooker et al. 1994). This has been accompanied by an increase in published literature reviewing this issue (see for example Barriball et al. 1992).

In spite of this growing interest in outcome-focused evaluation, few studies have attempted to measure the causal relationship between education and changes in nursing practice as observed in the practice setting. Even fewer studies have assessed change in gerontological nursing practice occurring as the result of an educational programme (Gifford 1994). Most evaluative studies use self-report measures such as questionnaires and interviews rather than observing for a change in practice (Chavasse 1994). Similarly, few studies in nursing have adopted an experimental design or randomised control trial, the 'gold standard' when attempting to identify causal relationships (Campbell and Stanley 1966).

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The lack of research-based evidence to support the notion of a causal link between programmes of education and changes in nursing practice may be related to the complex influences on human behaviour in a social setting. Ontological and methodological difficulties may frustrate attempts to adopt an experimental approach or use observational instruments. This chapter considers approaches to the evaluation of continuing professional education. Through a review of the literature, some of the methodological issues raised by outcome-focused studies in nursing and the allied disciplines are identified. The following approaches will be considered:

- post-programme single group design (including qualitative approaches)
- pre- and post-programme single group design
- post-programme control group design
- pre-and post programme control group design (randomised controlled trial)
- quasi-experimental design

Selected studies are used to illustrate some of the difficulties and advantages of the different approaches. The dearth of research evaluating gerontological educational programmes, has required a general consideration of approaches to the evaluation of continuing professional education in nursing and the allied disciplines. The review of non-gerontological studies suggests that similar methodological issues emerge in attempting to evaluate CPE regardless of discipline and practice setting.

3.2 Post programme single group design (including qualitative approaches)

A number of studies using a single post-programme assessment focus on the relationship between programmes of education and changes in the practice of participants (Heick 1981, Bignell and Crotty 1988, Hughes 1990, Cronnin-Stubbs 1992, Love et al. 1989, Greaves and Loquist 1983). Each adopts a post test single group research design and in each study, data are collected some months after completion of the educational programme, a recommended practice when looking for reliable educational effects (Heick 1981). However, despite the asserted focus on practice, all studies rely on self-report methods.

For example, Hughes (1990) reports an exploratory study using qualitative interviews to describe the impact of the ENB Course 941 (Nursing Elderly People) as perceived by the course participants and their managers. Hughes was course leader to the ENB Course 941 and a convenience sample was used. Tape-recorded, semi-structured interviews focused on the effects of the course on the professional, educational and individual development of course participants, and on their ability to improve nursing practice. Both participants and managers perceived that the programme had influenced the nurses' practice.

Heick's (1981) study was designed to measure the effects of an educational programme on nursing practice in the clinical setting (community maternal and child health care). The programme consisted of twelve one day taught sessions. Two months after completion of the programme all participants (n=63) and their supervisors were surveyed on the perceived value of the course content as applied to the participants' care delivery. Eight months following completion of the programme, selected community health care managers were interviewed using the same research instrument. Over 50% of the participants claimed that their practice had improved, with their managers attributing the improvement to participation in the course. Seventy percent of the supervisors indicated that the attitude of the participants toward maternal child health care had greatly improved. From her findings Heick asserts that the educational programme demonstrated a positive impact on care delivery. However, Heick defines 'positive impact' as a change in the participants' behaviour in the practice setting, whereas the questionnaires and interviews were designed to measure *perceptions* of behaviour change.

Bignell and Crotty (1988) and Cronnin Stubbs et al. (1992), focused on the practice behaviour of course participants (nurses) as observed by their managers. Bignell and Crotty (1988) evaluated the effects of the English National Board Course 923 (Developments in Nursing) using a questionnaire based on statements of critical functions. In their findings Bignell and Crotty reported that in the area of individualised patient care, managers gave an overall score of 97% for improvement in effectiveness and efficiency. However, the managers observations of students' practice may have been the cause of changes in the participants' behaviour rather than the educational programme. Although the validity of Bignall and Crottys' findings may be questioned, the particular value of this and the study by Cronnin-Stubbs is in their attempt to move towards observed practice as an outcome measure.

The main strength of the post-test research design is that participants are not sensitised to the subject of study. However, in the absence of a base line measure in the form of a pre-intervention assessment of practice, no definitive evidence of a change in practice can be demonstrated. The pre- and post-test single group design is an attempt to overcome this limitation (Chambers et al 1976, Harrison and Novak 1988).

3.3 Pre and post - programme single group design

Harrison and Novak (1988) used a modified pre- and post-test design to evaluate the effects of a gerontological nursing programme on the nursing care of hospitalised patients. The programme consisted of four two-hour classes over four weeks. The programme was offered twice (two four-week sessions) to all 550 registered nurses employed in a regional medical centre in South America. Each session was offered several times per week to increase accessibility. One hundred and forty-six nurses participated in one or more classes, but only 76 participated in all four. Part of the evaluation focused on elderly patients' satisfaction with and perceptions of nursing care. Sixty-three patients were interviewed, 30 prior to the educational programme and 33 following the programme. In their findings, Harrison and Novak highlighted that, contrary to their expectations the mean patient satisfaction and perception scores were lower after the educational programme than before, although the difference was not statistically significant. Because it was not possible to interview the same subjects before and after the educational programme, different groups of elderly clients were interviewed prior to and following the intervention. The ability of the researchers to determine a causal relationship with this approach is limited, since they were not strictly comparing 'like with like'.

3.4 Post - programme control group design

Attempts to evaluate the effects of continuing professional education face multiple threats to internal validity including maturation, history, testing, instrumentation, attrition (DePoy and Gitlin 1994) and sampling bias (Burns and Grove 1993). Introducing a control group into the design allows the researcher to compare the behaviour of those participants who have received the intervention with those who had not in an attempt to overcome such threats. Using a post-test control group design, Mahan et al. (1978) and more recently Carney et al. (1995) evaluated the effectiveness of educational programmes in modifying medical practice. The focus of Mahans' study was an educational programme designed to ensure proper diagnosis and treatment for patients with suspected malignancy. Effectiveness was measured in terms of the number and analysis of patient referrals in areas where physicians had been subject to the educational programme. Four centres specialising in cancer were selected: two received the educational programme and two received no programme.

By including a control group Mahan et al. (1978) were able to compare the number of referrals made by those physicians who had undertaken the programme with those who had not, thereby increasing the internal validity of the study. In this way the researchers were able to infer that the independent variable, rather than uncontrolled extraneous factors, was responsible for the observed effects. This study and the research by Carney et al (1995) had the additional advantage of including a non-sensitising base line measure. The researchers were able to collect data prior to the introduction of the independent variable using the documented number of patient referrals for the preceding years. In this way comparisons of referral practices could be made before and after the introduction of the educational programme without alerting the participants to the main objective of the study.

In relating their findings Mahan et al. (1978) reported that from one study site there were 50 new cancer patient referrals in the twelve months following the introduction of the seminar, compared with 20 new cancer patient referrals from the same site in the year prior to the seminar (chi-square = 12.34, 1*df*, $p< .01$). Similarly, at another site the number of new patient referrals following the seminar was 19 compared with 6 new patient referrals in the preceding year (chi-square + 6.76, 1 *df*, $p < 0.01$). At the control sites where no programme on cancer was presented there were no statistically significant differences. This study provides evidence to support the view that continuing professional education has an effect on practice.

3.5 Pre and post programme control group design (randomised control trial)

The pre and post test control group design is the most commonly used experimental design (Burns and Grove 1993) and is characterised by manipulation, control and randomisation (Campbell and Stanley 1963, Polit and Hungler 1991). Some commentators suggest that experiments offer the most convincing evidence concerning the effects of one variable on another (Polit and Hungler 1991, Davis et al 1992). Pre- and post-test control group design has been used to evaluate the effects of education on practice in medicine (Inui et al. 1976, Laxdale et al. 1978, Evans et al. 1984, White 1985, Chassin 1986, Maiman et al. 1988, Cummings et al. 1989, White et al 1989) pharmacy (Benfield 1977), dentistry (Chambers et al. 1976), nursing (Le Compte et al. 1972, Oliver 1984, Ross et al. 1988 , Goldrick et al 1990, Dunn et al. 1992, Cronnin-Stubbs et al. 1992, Thomas et al.1993, Brambles 1994), and within mainstream education (Kreft and Aschbacher 1994).

Randomisation is addressed in various ways. In some studies, individual settings such as hospitals are randomly allocated to either the experimental or control group (Laxdale et al.1978, Chassin and McCue 1986, Dunn et al. 1992). Alternatively, subjects within each hospital or educational centre are randomly assigned (Thomas et al. 1993, Inui et al. 1976, Kreft and Aschbacher 1994). Each approach has advantages and disadvantages in relation to the internal validity of the study. The randomisation of settings, rather than individual subjects, avoids cross-contamination between the control and experimental subjects working in the same setting. However, there may be little consistency in conditions across the two groups. The differences in workplace may affect the subjects' ability to use the content of the educational programme, thereby affecting the outcome of the study. The reverse is true with the random allocation of subjects. On the one hand, differences in the workplace are likely to be distributed across the control and experimental group, but on the other there is the risk of cross-contamination. Controlling for the effects of confounding variables like the work setting and, in particular, the intrinsic motivations or abilities of participants, is a built-in safeguard of some studies (Kreft and Aschbacher 1994, Solarsh et al. 1982).

Solarsh et al (1982) designed a randomised control trial (RCT) to evaluate whether nurses' clinical competence differed if they were trained using diagnostic flow charts or using traditional patient-centred teaching. Over a period of five months nurses (n=9) were trained in the principles of history taking, examination, diagnosis and management. Following the period of instruction the clinical competence of each nurse was assessed with a different group of 20 patients. The same two doctors were involved in all the assessments, re-examining patients independently. At the end of each day each doctor independently assessed the nurses' findings against his own and awarded a mark on a 10 point scale (1=lowest score of clinical competence, 9=highest score of clinical competence). Since the trial design required an even number of nurses, the nurse with the highest score who had least opportunity for further improvement, was then excluded from the trial.

Using this pre-test measure of clinical competence, Solarsh et al (1982) ranked the remaining eight subjects and identified four pairs of nurses with similar levels of practice. This had the effect of enhancing the overall compatibility or homogeneity of the groups (Polit & Hungler 1991). Nurses within each pair were randomly allocated to either training with flow-charts or conventional training. From then on the two groups were trained separately and asked not to discuss their flow charts with members of the other group. The post test measure of clinical competence took place following one month of training. Each pair of nurses were assessed on a different group of patients.

Solarsh et al (1982) reported that nurses trained with flow charts did not improve their clinical competence significantly more than those trained without them. There was a mean improvement however, from the first to the second measure for both groups. In other words clinical competence improved from the first assessment to the second assessment whether nurses in either group used the diagnostic flow chart or conventional methods.

This study highlights some of the complexities of attempting to use an experimental design to evaluate an educational programme. As in Harrison and Novak's (1988) study, the before and after measures were carried out on different patients, again making meaningful comparisons difficult. The lack of a standard intervention also brings into question the internal validity of the study. No attempt was made to standardise the nature and delivery of the taught sessions. Whilst the content of the sessions was meant to be the same, the instructor input at each session inevitably depended on their individual style.

The strength of Solarsh et al.'s study is in the homogeneity in the clinical competence of the matched pairs of nurses pre-randomisation. Adopting this approach meant that any improvement in clinical competence in the nurses' use of the flow chart over other forms of assessment, was likely to be the result of the flow chart (the independent variable) rather than extraneous variables. The study would have been strengthened had the sample been matched on additional criteria such as: age, gender, clinical experience, place of work, and ethnicity, since these factors may have influenced the nurses' ability to use the flow chart. However, it is worth noting the difficulties in generating a sample when the inclusion criteria are strictly defined. Indeed, matching on clinical competence alone required Solarsh and co-workers to invest in an intensive educational programme pre-randomisation. Any statistical significance in terms of educational impact would need to be evaluated in the context of the small sample.

3.6 Quasi-experimental design

The nature of some experimental studies means that the random assignment of participants is not possible (Benfield et al. 1977, Bramble 1994, Brown et al 1994). When subjects cannot be assigned randomly to groups a quasi experimental design provides an alternative (Cook and Campbell 1979, Ross et al. 1988). One approach is to allocate participants to the intervention and control group according to the timing of the independent variable or educational programme. Bramble (1994) assigned subjects to the control or the experimental group based on the semester in which they commenced the course. The groups were studied one year apart, the control group (n=18) preceding the experimental group (n=11). In an alternative approach, Brooker and Butterworth (1991) used a matched control group in a study to evaluate training in psychosocial intervention for community psychiatric nurses. The experimental group (n=9) were selected from three Regional Health authorities on the basis of an interview. The control group were then identified by matching each experimental CPN with a similar CPN from the same health authority. The limitation of this approach is the difficulty of matching on all relevant criteria.

One of the methodological issues raised by collecting data before and after the introduction of the independent variable, is that the pre-test measure has the potential to distort the research findings, in that the post-test measure may be affected by exposure to the pre-test (Polit and Hungler 1991). Benfield et al.(1977) addressed this by adopting a 'Solomon Four Group Design'. Their study involved two experimental and two control groups. One experimental group and one control group were administered the pre-test and the remaining groups were not. This allowed the effects of the independent variable and the pre-test to be isolated.

The extent to which research has demonstrated a causal relationship between education and practice has formed the focus of a meta analysis (Waddell 1992). A total of 34 published and unpublished evaluation studies were included in the analysis with studies selected using the following criteria:

- the intervention consisted of a programme of continuing nurse education
- the effect of the treatment was assessed by examining practice-related behaviours or chart audits which documented practice
- there were sufficient data to compute an effect size

On the basis of the review, Waddell suggests that we can have greater confidence in the assumption that continuing education has an impact on practice. However, more than one third of the studies failed to report the reliability and validity of the instruments used to measure the effects of education on practice. Whilst all 34 studies were found to be testing the hypothesis that continuing education has a positive effect on nursing practice, in the absence of information on the validity and reliability of tools to measure practice Waddell's conclusion must be viewed with caution.

3.6 Summary and implications for the present study

This review has focused upon the methods used to evaluate programmes of continuing education in nursing and related health disciplines. If the main purpose of continuing nurse education is to improve the quality of nursing care, it is the responsibility of those involved in nurse education to evaluate its effectiveness in this respect. Clinicians are increasingly required to produce evidence of research-based practice (Briggs 1972, Department of Health 1989, Mulhall 1995). Educationalists, as a key link in the research-practice chain must also demonstrate the outcome of their programmes. Evaluating the causal link between education and practice suggests the need for experimental research. However, as the literature suggests, the relationship between education and practice is highly complex, consisting of a web of variables which are difficult to disentangle.

Methodological difficulties aside, research evaluating the effects of education on the care of older people has identified a contribution to improving and/or sustaining quality care (Hughes 1990, Harrison and Novak 1988). While there are only a few studies evaluating the effects of education on the care of the older person, there is a growing body of evidence reporting changes in the attitudes, knowledge and practice of participants attending programmes of education. Disentangling the complex relationship between an educational programme and changes in the care of the older person appears to have been dealt with more effectively when the research includes the perceptions of the clinical nurse manager as well as the nurse. The perceptions of the manager help comprehend the context in which changes in practice take place (Hughes 1990). In addition, the manager describes changes in the knowledge and practice of nominees which tend to go unnoticed by the nominee.

This review has confirmed the need for additional research into nurses' ability to effect change in gerontological nursing practice as a consequence of undertaking an educational programme. Kuramoto (1985) suggested that most research evaluating continuing nurse education is planned with insufficient methodological sophistication to provide definite results. The problems which Kuramoto cites include small sample size, poorly constructed instruments for data collection and inappropriate or weak experimental design. The findings of this review suggests that these limitations apply to studies of educational programmes for the care of older people.

These shortcomings may be the result of the conceptual and methodological difficulties of attempting to use an experimental design within an educational context. For example, control and manipulation may be viewed as antithetical to the current ethos of encouraging participation in care, fully informed consent and freedom of choice (Brearley 1990). Wilson-Barnett (1991) provides useful suggestions for improving the experimental approach with human subjects to take into account some of these issues. She suggests the following modifications:

- researchers should share their ideas to ensure they are not irrelevant or unimportant to participants
- informed consent can be given to subjects and may enhance understanding by tailoring interventions to suit subjects' preferences
- the control group can be provided with a meaningful intervention
- the collection of qualitative data to complement the experimental design can provide information on the meaning of the situations to subjects and their experience
- subjects should receive debriefing in a relevant and planned way
- presentation of experimental research should describe clinical significance in order to be more relevant to practice (Wilson Barnett 1991).

The challenge of isolating the effects of the independent variable from those of extraneous confounding variables is difficult in any study of human subjects (Seaman and Verhonick 1982), perhaps more so in an educational context where the researcher is dealing with the complexities of learning and attempting to measure the effects of learning in an equally complex clinical environment. This complexity may frustrate attempts to use an experimental design. And yet, the complexity is perhaps the very reason to adopt an experimental approach, systematically examining relationships one by one. An examination of multidimensional relationships is characteristic of several clinical trials (Lenhard et al. 1978, Needleman et al. 1979) with the design allowing for multiple end points or outcome measures (Pocock 1994). Research in continuing nurse education may or may not learn and benefit from adopting this approach. What is certain is that continuing nurse education must demonstrate its value, particularly if it is to compete effectively for a share of available resources.

Collectively, these points confirmed to the research team that an experimental approach would meet some of the objectives for the current study. However, the literature review also confirmed the need to triangulate evidence from a controlled experiment with qualitative data on the perceptions and experiences of nurses working with older people in order to provide more comprehensive answers to the research questions.

SECTION 2

EMPIRICAL WORK: METHODS AND FINDINGS

Survey of educational programmes for the care of older people

Survey of continuing care facilities

Attempts to set up a randomised controlled trial to evaluate the ENB Course 941(Nursing Elderly People)

Evaluation of the ENB 941 programme (Nursing Elderly People): methods

Evaluation of the ENB 941 programme (Nursing Elderly People): findings

Chapter 4. Survey of educational programmes for the care of older people

4.1 Introduction In order to identify aspects of a range of educational programmes relating to the promotion of independence and autonomy among older clients and patients, a national survey of educational centres providing pre- and post-registration education was undertaken. In June 1995 a self-completion questionnaire was sent to course leaders for a representative sample of programmes. Information derived from the questionnaire was complemented by a content analysis of selected programme curricula.

4.1.1 Sample Principals/Heads of all educational centres in England offering programmes in nursing felt to meet the inclusion criteria (n = 172) were identified from lists provided by the ENB and informed about the study in writing in early March 1995. This initial letter invited recipients to contact the research team if they felt their organisation was engaged in 'innovative' practice in relation to the care of older people. Twelve centres responded to this initial contact and this information was useful in informing the development of instrumentation for this phase of the study.

A random sample of all educational programmes in nursing in England likely to have content relating to the care of older people England was then identified (N = 130). Each type of programme was numbered using lists provided by the ENB and a random sample was drawn using random number tables until the requisite number of programmes had been identified. An attempt was made to identify a minimum of ten examples of each type of educational programme in order to allow comparisons. However, the sample was weighted towards the more ageing focused courses (ENB 298 and ENB 941)and more of these courses were sampled. This was because it was felt that nurse teachers and lecturers involved in these programmes would be likely to have more to recount in relation to innovative practice in this field. The analysis of the ENB 941 programmes (Nursing Elderly People) was also to inform Phase III of the study. No more than three different educational programmes were identified for the same centre in order to avoid making excessive demands on any one centre

The Principal of each centre (n=72) was asked to consent to involvement in the study and 90% (n= 65) of Principals responded positively at this stage. A small number of centres (n=6) declined to participate and a few replied that they no longer offered at least one of the programmes we were interested in (n=8), although they gave permission for us to access information relating to other programmes. An attempt was made to randomly replace these programmes in order to maintain our original sampl; however, this was not always possible due to the number of programmes of any one type available. The timescale for the study also meant that a cut-off point for recruitment needed to be adhered to.

This process of negotiating access resulted in a final sample of 102 programmes in 67 educational centres (Table 4.1). Each programme leader was sent a detailed self-completion questionnaire in June 1995 (Appendix II). The questionnaire included a combination of open and closed questions to explore the following areas:

- range of people contributing to the programme
- teaching and learning methods
- objectives relating to the care of older people

Curriculum documents Course curricula for a 50% random sample of the programmes surveyed in the questionnaire study were accessed via ENB Regional Offices and copies were made with the written permission of the Principal of each centre. Given the focus on the ENB Course 941 (Nursing Elderly People) planned for Phase III of this study, as many curriculum documents as possible were accessed for this programme (n = 18). The total number of curriculum documents reviewed was 69, comprising 25 pre-registration and 44 post-registration programmes (Table 4.1).

4.1.2 Data analysis

Questionnaires were post-coded for computation and analysed using the Statistical Package for the Social Sciences (SPSS(windows)version 6.0 (Microsoft 1993)). Frequency tables and descriptive statistics were computed for closed responses and a series of cross tabulations performed to begin to describe the relationship between

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course type and selected variables. Differences between cells in cross-tabulation were analysed using the Chi-squared statistic.

Open ended responses were transcribed in full onto a database and content analysed for themes. Where themes emerged, data were post-coded by two researchers independently and checked for consistency. Discrepancies were discussed and agreement reached. Frequencies for the post-coded responses were then computed.

Relevant data within each curriculum document were colour coded, and located in a matrix under the following headings:

- Students per intake
- Frequency of programme
- Length of programme
- Admission criteria
- Programme philosophy
- Curriculum model
- Programme aims and objectives
- Learning outcomes
- Teaching and learning strategies
- Content (theory)
- Content (practice)
- Assessment
- Links between research/theory/practice
- Evaluation
- Specific items (relating to the promotion of patient/client autonomy/independence)

The work of analysing the data was shared between the three principal researchers. In addition, a group of undergraduate students analysed a selection of the documents as part of an assessed group project under the guidance of the project co-ordinator. The students analysed the focused courses (ENB Courses 298 and 941) using the framework developed by the research team. Key words and phrases were identified based upon the review of the literature and extracted onto matrices by two people independently and cross-checked This helped toachieve consensus and ensured there were no major differences in interpretation among members of the student group. Regular discussions took place between the student group and the research team to ensure that the student group were fully aware of the objectives of the analysis The research team then used the same process to analyse the remaining programmes (i.e. those not specifically focused on the care of older people). The rationale for analysing the focused programmes first was that the objectives for these programmes (as determined by the ENB) specifically reflect the dimensions of interest to the study. The analysis of ways in which these precise objectives were operationalised within the focused programmes informed the analysis of the remaining programmes, where the focus on the needs of older people was often less explicit.

The completed matrices facilitated the identification of themes and the comparison of individual programmes. In particular, the research team were alert to differences of emphasis between types of programme.

4.2 Findings - Course Leader Questionnaire

4.2.1 Response rate A total of 102 questionnaires were sent to programme leaders. Following one postal follow-up and a telephone reminder, 77 had been returned, a response rate of 75.5% (Table 4.1)

To gauge the accuracy of the curriculum documentation as a representation of the way in which each programme was currently being delivered, programme leaders were asked whether there had been any significant changes to the curriculum since validation. Just under half (46.6% n=35) reported that there had been changes. No clear pattern emerged in relation to the description of these changes: however 15 (20%) of programme leaders reported changes related to placements in an attempt to strengthen links between theory and practice. For example:

> *Clinical practice has been split into components rather than 10 weeks in one go*
> (ENB 298)
>
> *The first term of the branch has been changed to reflect community care placements with locality teams*
> (Mental Health Branch)

Table 4.1 *Educational programmes included in survey*

Educational programme	Sample (N)	Response (n)	Curricula (n)
Pre-reg. Diploma - Common Foundation Programme	9	6	5
Pre-reg. Diploma - Adult Branch	9	9	5
Pre-reg. Diploma - Mental Health Branch	6	4	5
Project 2000 - Learning Disabilities Branch	9	8	5
Undergraduate nursing degrees	9	5	5
District Nursing (Diploma)	6	5	5
Health Visiting (Diploma)	7	6	5
Practice Nursing	5	5	5
Community Psychiatric nursing (ENB 812)	6	5	5
ENB course 941 Nursing Elderly People	24	16	18
ENB course 298 Nursing Elderly People	12	8	6
TOTAL	**102**	**77**	**69**

A few respondents identified changes which suggested an increasing awareness of issues relating to the care of older people:

> *More emphasis on current issues related to ageing - a positive approach; empowerment, elder abuse awareness; controversial issues/ethics-euthanasia, complementary therapies-reflexology, validation therapies*
>
> (ENB 941)

However these were a minority of responses and were mainly from leaders of specialist elderly care programmes.

4.2.2 Approaches to teaching and learning

Methods Nearly all programme leaders identified a range of teaching methods used within the programme, specifically lectures (95%) seminars (97%) self directed learning (96%) and student-led presentations (99%). A similar proportion (90%) reported the use of experiential learning techniques. Just under half (45% n=35) reported a group size of twenty or less for lectures, whereas five respondents reported group size of a hundred or more. Reported group size for seminars ranged from 4 to 40 students with a median of 12. Twenty two programmes run seminars with 20 students or more.

Contributors to the programme Course leaders identified a wide range of nurses in practice contributing to each programme. Ninety-four separate nursing roles were identified. The most frequently occurring responses were, diabetes nurse (n=18), clinical nurse specialist (unspecified) (n=9), continence advisor (n=8), behavioural therapist (n=8) and CPN (n=8). Not surprisingly the number of nurse contributors varied between programmes, with the longer programmes involving a larger number of contributors. In terms of non-nurse contributors 75 different role titles were identified. Common responses included physiotherapist (n=18), doctors/geriatricians (n=17), dietician/nutritionist, (n=17) social workers (n=14), psychologist (n=12), pharmacist (n=12), and health promotion officers (n=9).

Very few programmes include any teaching contribution from service users. Three course leaders (one ENB 298 programme, one ENB 941 programme, one mental health branch) stated that informal carers contribute to the programme, and one course leader identified user group involvement. Only one course leader (ENB 941) identified contributions from a lawyer and a specialist in ethics.

Helping students make links between theory and practice The questionnaire invited course leaders to identify strategies within each programme designed to help students make links between the theoretical components of the programme and practical experience. Seventy six respondents (99%) identified at least one strategy. The most frequent responses were: reflection on practice sessions (n= 18), use of a reflective journal (n=17) and critical incident analysis (n=9). Many respondents identified the role of the practice facilitator or mentor in helping students to make the links. Alternative approaches included:

- *use of a practice theory link sheet* (Diploma in Health Visiting)
- *group tutorials led jointly by teacher and practitioner*
  (Learning Disabilities Branch and Pre Registration Degree in Nursing)
- *user input to some sessions* (Adult Branch, Mental Health Branch)
- *work book linking ageing theories with course members' experience*
  (ENB 941 and 298 and ENB 812 and Practice Nurse Course)

Respondents were also asked to describe any strategies within the course for *assessing* students' ability to make links between theory and practice. All respondents (n=77) described at least one assessment strategy. The most frequently cited were:

- assignments linked to practice topics (n=22)
- branch assignments/exams (n=15)
- learning contracts reflecting the integration of theory and practice (n=13)

Negotiation Respondents were asked whether there were opportunities for students to negotiate course content within each programme. The vast majority replied that there were (n=70 91%) and 46 course leaders gave examples. The most common response was that students had the opportunity to influence teacher led input (n=35) A smaller proportion (n=12) identified negotiation in relation to student-led sessions such as seminars and conferences. Eleven respondents identified formal mechanisms such as representation on course committees whereby students could influence course content. Only a small number (n=7) suggested that there were opportunities within the programme for course members to negotiate practice placements.

Additional comments suggested that, for a few programmes, opportunities for course members to negotiate content were limited by the demands of the prescribed curriculum. For example:

> *Length of branch programme doesn't allow for a great deal of choice*
> (Learning Disabilities Branch)

> *Content at present governed by ENB approval, though students are encouraged to link to their own practice area* (ENB 941)

It is worth noting that one course leader for the Common Foundation Programme expressed the view that elective topics on ageing should be compulsory.

We asked respondents whether course members were able to negotiate course work and a large proportion (n= 60 78%) identified such opportunities. Two themes emerged: one, that within broad guidelines course members could choose the focus of assignments and the other, that essay titles allow scope for course members to draw upon their own personal and professional experience.

> *Students (are) asked to present a health profile of a client and critically evaluate the impact that society, through social policy and attitudes has on their care* (Mental Health Branch)

Three respondents suggested that the possibility of negotiation related only to formative assignments. Two course leaders (one ENB 941 and one Diploma in Health Visiting) indicated that course members needed to approve topics with clinical managers in order to ensure relevance to the workplace.

4.2.3 Programme objectives

Relationship to other programmes of study We invited course leaders to comment on ways in which the course might complement or build upon other programmes of study. Nearly all who commented were course leaders for the ENB focused courses the ENB 941 and 298. Some programmes were foundations for Diploma and Masters programmes. In other centres they contribute to a Diploma in nursing in a modular fashion. A few respondents identified links between the Common Foundation Programme and branch programmes.

Objectives specific to the care of older people Respondents were invited to rank from 1 to 6 *(1= most important, 6= less important)* the priority allocated within the programme to each of a series of objectives taken from the curriculum guidelines for the ENB course 941 (Table 4.2). The two objectives which relate most closely to the dimensions of interest in relation to the promotion of autonomy and independence were afforded the highest priority by 76% and 60% of respondents respectively. However there was a reluctance to rank any of the objectives as having least priority. Of note, the objective which most frequently ranked in sixth place related to awareness of mental health legislation and the value of health promotion for older people.

Table 4.2 ***Priority of objectives taken from curriculum guidelines for the ENB 941 course within all educational programmes***

Objective	**Ranked 1st or 2nd Priority %**	**Ranked 6th Priority %**
develop an understanding of the physiological, psychological and sociological effects of the ageing process	45.4	2.7
promote the adoption of a holistic approach to the care of elderly people incorporating their individual physical and psychosocial needs, beliefs and value systems	76.0	4.0
develop the ability to identify and implement appropriate action which will enable the elderly person to return to and maintain self-help skills and independence	60.0	5.3
discuss the relevance of a multi-agency approach to the care of elderly people and understand the role of the nurse within the team	38.7	5.3
develop awareness of the value of health promotion and primary health care provision for elderly people	30.7	8.0
develop an awareness of mental health legislation as it relates to the elderly mentally ill person	22.6	40.0

Practitioner involvement in the development of curriculum Sixty eight respondents (88%) stated that practitioners were involved in developing course curricula as members of the course team. However, this was qualified by comments suggesting that practitioners often found it difficult to attend team meetings:

> *They express problems about being able to leave their work for such purposes*
> (Undergraduate Nursing Degree)
>
> *This works well with someone who is positive and enthusiastic - all too often other pressures prevent the practitioner from being a team member*
> (ENB 298)
>
> *The speed at which we are asked to develop courses makes collaboration very difficult* (ENB 298)
>
> *Not many make use of the opportunity or can fully understand content of discussion - patronising I know, we should make our discussions more accessible* (Learning Disabilities)
>
> *Have always been invited. Large interest and presence during course development but less so now* (Undergraduate Nursing Degree)

Some programmes appear to go to great lengths to ensure practitioner involvement:

> *Community practitioners are involved at every stage and in fact write the content of the course which is then transcribed into Departmental format for validation* (District Nursing)
>
> *Some practitioners make a valuable contribution: the College has tended to recruit these from medicine/surgery and not older persons' services in the early stages* (CFP)

User involvement in development of the curriculum A much smaller proportion of course leaders (n=25) identified that service users are involved in curriculum development. On the whole this appears to be through advocates and special interest groups rather than service users. More of the programmes with a focus on mental health and learning disabilities involve users themselves (although this difference was not statistically significant - chi-square 4.405, DF 1, p=0.358). Few of the ENB focused courses and none of the health visiting programmes appear to involve users in curriculum development. Some of the comments illustrate the reasons for this:

> *Generally through special interest groups as severe learning disabilities preclude direct contribution* (Learning Disabilities Branch)

> *This would be an extremely difficult administrative exercise* (Diploma in Health Visiting)

It was apparent from some responses that a few course leaders had interpreted service user to include purchasers and providers:

> *Managers are members of Course Management Team but few are actively involved* (ENB 941)

Comments suggested that many course management teams are actively considering how service user input can most effectively be managed. For example:

> *At present trying to identify consumers and how best to get a true representative. Working party looking at how we can integrate users meaningfully* (Adult Branch)

Several course leaders identified the role of educational audit in seeking users' views:

> *During educational audit (yearly in each care area) the opinion of patients are* (sic) *sought and asked specifically about nurse training* (Adult Branch)

A small number of respondents highlighted the danger that user involvement could be tokenistic in the absence of clear objectives.

Methods of evaluation We were interested to explore mechanisms for evaluating each programme and opportunities for course members, teachers, practitioners and service users to influence the curriculum. Formal mechanisms for course evaluation are indicated in table 4.3. There appears to be ample opportunity for students to express their views in relation to each programme, however it would appear that the views of teachers and practitioners are less frequently sought.

Programme content: social policy Nearly all respondents identified a social policy content to their programme. However only 57 course leaders (74%) identified social policy content specific to the care of older people. The most common response related to Government Acts and reforms with implications for older people such as the NHS and Community Care Act and *Working for Patients*. Thirteen (17%) course leaders mentioned content relating to financial benefits including pensions. Specific content which could be more clearly related to the dimensions of interest for this study were identified by nineteen (25%) course leaders. Of these, nine were course leaders for the focused programmes (Table 4.4).

Table 4.3 ***Mechanisms for course evaluation***

METHOD	More than once per intake %	Once for each intake %	For some intakes %	Never %	TOTAL
Self-completion questionnaire to course members	68	29	0	3	**72**
Self-completion questionnaire to teachers	23	23	14	40	**57**
Discussion (students and teachers)	88	9	3	0	**75**
Discussion (students and practitioners)	65	21	9	5	**65**
Staff/Student Course Committee	68	18	3	11	**66**
Course Curriculum Management Team	63	26	5	5	**73**

Table 4. 4 Courses including social policy content specific to the care of older people

Programme	Responses (n)	Specific content identified
ENB 941	16	6
ENB 298	8	3
Adult Branch	9	3
Common Foundation Programme	9	2
District Nursing	5	2
Nursing Degree	5	1
Learning Disabilities Branch	8	1
Mental Health Branch	4	1
Health Visiting	7	0
Community Psychiatric Nursing	6	0
Practice Nursing	5	0

The specific content included the following topics:

- ethical context, justice and allocation of resources
- issues of oppression/minority status
- attitudes toward the elderly/negative images and the elderly
- retirement and exclusion of elderly people from the work force
- social policy and the construction of dependency in later life
- social policy debate re quality care and cost containment
- assumptions underlying changes in service provision
- economics of ageing and health care
- human rights
- access to health care provision

In order to explore whether course members had the opportunity to consider the impact of both professional guidelines and government initiatives on patient/client care, the questionnaire asked if there were specific sessions to debate the implications of both the UKCC Code of Conduct and the NHS Patients' Charter for their practice. The majority of course leaders(n=65 84%) identified at least one example of each within their programme. Most occurred within a general discussion of professional accountability, legal and ethical considerations, and consideration of rights, infringements on rights and professional responsibilities. Less frequently mentioned were issues of risk taking and restraint (n=2), confidentiality (n=3) and informed consent (n=3). One course leader warned against the possibility of overload in relation to these topics:

> *if anything too many opportunities !* (to use UKCC Code of Conduct) *All teachers appear to use it - some overkill*
>
> (Common Foundation Programme)

A course leader for the ENB Course 298 suggested that the Patient's Charter was no longer of key importance, and had been superseded by a focus on issues such as 'living wills', 'advanced directives' and decisions to treat.

Content specific to the promotion of autonomy and independence for older people

Course leaders were asked to identify the extent to which issues of relevance to the promotion of autonomy and independence featured within their programme. Responses are shown in table 4.5. All except one of these issues appear to be thoroughly discussed or to form the basis of project work. The issue of managing risk in relation to patient/client safety appears to have less prominence within some programmes with the focused courses (ENB Course 941, 298) more likely to ensure that the issue is thoroughly discussed. In fact over a quarter (n=16, 27 %) of the programmes which were not focused specifically on the needs of older people indicated that the issue was only mentioned.

In response to a question asking course leaders to identify modules and units within the programme where the promotion of patient/client autonomy and independence features as a topic, over a third (n=26 34%) responded that these concepts represented a theme running throughout many of the sessions. Autonomy and independence were fundamental values which were implicit and formed an integrated part of all patient related sessions. Others suggested that they featured particularly on modules on health promotion (n=16 21 %), professional issues (n=9 12%), and ethics and legal issues (n=7 9%). A number of course leaders commented specifically on the promotion of independence.

> *As Community Nursing is about promoting independence I would suggest that all the modules of the programme feature this area*
>
> (District Nursing).

> *Lifespan seminars and assignments: students relate and emotionally analyse the patient's experiences of adaptation to enable the development of client centred skills* (Health Visiting)

Table 4.5 ***Extent to which issues relating to autonomy and independence are covered within programme content***

Topic	Not at all %	Mentioned %	Focus Topic %	Thoroughly discussed or project %	TOTAL (n)
The promotion of patient/ client choice	0	8	36	56	**75**
The special needs of elderly people	0	12	38	50	**76**
Patient/client participation in care	0	8	36	56	**75**
Individualised needs assessment	0	3	29	68	**76**
Promoting independence and self care for patients/clients	0	8	37	54	**75**
Managing risk in relation to patient/client safety	0.0	22.7	50.7	26.7	**75**

Ability of programme to enable nurses to promote autonomy and independence

Course leaders were invited to consider whether the programme enabled nurses to promote the autonomy and independence of older people in their care. The majority (n = 64 83%) were of the opinion that it did. However, four course leaders suggested that their programme did not succeed in this respect and the remainder were undecided. It is notable that the majority of these were course leaders for community based programmes:

> *At present I would say the course is too short to do enough in this area. The new degree course should give the time to do this* (Practice Nursing)
>
> *Not overtly addressed but philosophy of course embraces these issues. The course is designed for five professional branches* (ENB Course 812)
>
> *This is difficult to answer since these are core skills/attributes in District Nursing and if we do not enable the students to achieve them we have failed* (District Nursing)

> *Difficult to say specifically elderly. Whole course with a total population approach designed for student to determine (their) future role as a Health Visitor working effectively with individuals, families, groups and communities* (Health Visiting)
>
> *Probably not sufficiently* (Health Visiting)
>
> *You can't say that a course enables this - I feel it depends on the individual's attitudes to the elderly and ethos regarding health promotion and the elderly* (Health Visiting)
>
> *Only to a certain extent* (Learning Disabilities Branch)
>
> *Due to organisation of course limited teaching sessions can be allocated to older people* (Mental Health Branch)
>
> *The course programme pays little attention to the needs of older people except in electives run by committed and effective teachers* (Common Foundation Programme)
>
> *I feel the course provides them with the necessary information and raises awareness of the issues, however I think there are other enabling factors which could influence them to a lesser or greater extent. Many work in areas where the stereotype of older people remains quite prominent. I feel the medical profession need to come on my course* (ENB 941)

Course leaders offered some reasons why the concepts 'autonomy' and 'independence' are difficult to include in the programme or promote in clinical practice. A course leader for the focused programme (ENB 298) highlights the dilemma of balancing the notion of safety with the promotion of autonomy and independence.

> *Nurses are sometimes hidebound by safety considerations as they feel responsible* (ENB 298)
>
> *Their problems start with lack of support to see things through* (ENB 298)

Although the majority of course leaders (n = 64 83%) felt the programme enabled nurses to promote the autonomy and independence of older people, there was less specific evidence on how this was achieved. Responses were many and varied (82 different responses), however the following themes emerged:

- autonomy and independence are themes running throughout the course
- focus upon individualised care
- theory-practice focus
- emphasis on challenging attitudes and stereotypes
- developing the skills to challenge and change practice
- participation as a theme running throughout

Changes to the programme Sixty three per cent (n=55) of course leaders identified at least one change which they would like to make to the programme. The most frequently suggested change was for the programme to become more practice focused for example;

> *increased involvement of students in community nursing and outreach type placements e.g. increase time in practice by 100% (from 8 to about 20 weeks)*
> (Learning Disabilities Branch)
>
> *more practice orientated increasing student-patient contact* (Adult Branch)

Some respondents identified the need to strengthen further the links between theory and practice, for example by conducting more tutorials in clinical practice settings. Eight respondents identified changes in course content related specifically to the needs of older people: however seven of these were course leaders for the focused programmes the ENB 941 and 298. For example:

> *The emphasis I plan is more socio-political. I take a very radical anti-ageist stance and do not include subject matter which is pathological*
> (ENB 941)
>
> *At present* (the course is) *presented over two modules - need to make sure that the module related to normal ageing is accessed first* (ENB 941)

4.3 Analysis of curriculum documentation

This section considers the curriculum documentation for the sub-sample of programmes (n = 69) and identifies the ways in which the dimensions of interest for this study are currently reflected within pre- and post-registration nurse education in England.

As described in Section 4.1.3, information was transcribed onto matrices under a series of headings. The findings of this analysis are presented here under the headings: programme philosophy; aims and objectives; content; teaching and learning strategies and assessment. These areas include identification of specific items relating to autonomy and independence and to links between research, theory and practice. For clarity of presentation programmes are grouped as follows: pre-registration programmes; community post- registration programmes; programmes focused on the needs of older people (ENB 941 and 298).

4.3.1 Programme philosophy

The process of identifying key themes within the course curricula was hampered by the differing interpretations of 'philosophy' which were apparent from the documentation. Some course teams had incorporated a philosophy of nursing, others a philosophy of teaching and learning. Some identified core values which would provide a framework for the curriculum. The more comprehensive philosophy statements covered all of these aspects. In attempting to compare and contrast the philosophical bases of different educational programmes, it was necessary for the research team to be alert to statements which reflected such underpinnings throughout each document and not rely on the stated course philosophy to provide this information.

In the analysis of the course philosophies for the pre-registration and community-based programmes, a number of common themes emerged. The importance of viewing health as a value and a basic human right is mentioned in nearly all curricula, as is the need to create flexible, autonomous practitioners, equipped to adapt their practice to the ever-changing demands of the health care system. Most curricula identify a commitment to recognising the uniqueness of individual students and to encouraging each student's active participation in the learning process. The importance of demonstrating clear links between theory and practice is a recurrent theme.

Mention of teamwork and collaboration with other professionals and with service users is more variable. Post-registration programmes aimed at preparing nurses for community practice (Diploma in District Nursing, Diploma in Health Visiting, Certificate/Diploma in Practice Nursing) all emphasise the role of the nurse within a multi-disciplinary team. Linked with this is an emphasis on shared learning, which was much less apparent within the pre-registration curricula. Surprisingly, given the current emphasis on consumerism and participation identified within the literature, less than half of the curricula specifically identify the notion of partnership with patients and clients as a fundamental principle influencing the course design.

Those programmes aimed at preparing practitioners to work in the fields of mental health and learning disabilities are more explicit about the nature of the relationship between nurse and client or patient. One ENB course 812 aims to:

> *...produce a practitioner who is able to offer a supportive and empathic relationship which does not foster dependency but rather looks to enable the client to regain a foothold in the process of health.*

We would argue that an understanding of the nature of this relationship is fundamental to the identification of course aims and objectives. However, there appears to be less of a focus on the nature of the nurse/client relationship and on fundamental values such as the rights of the individual within the DN/HV/PN courses. This is reflected in limited mention of user participation and partnerships in care. Although health promotion features prominently as a focus, recognition of the potential for community health development through a process of empowerment is absent from nearly all the community nursing programmes reviewed.

No major differences were identified between the philosophies of the ENB 941 and ENB 298 courses. The most common themes are that older people have rights and choices, should be treated as individuals, that their wishes and views should be respected and that they should be able to maintain their independence. Some (but not all) curricula go a stage further in arguing that older people need to be empowered to enable them to be involved in decisions affecting their health care:

> *The negotiation of care with the patient or patient's support network and the concepts of empowerment and informed choice are important aspects of the care of the elderly, so the nursing role, in relation to this, forms part of the course curriculum.*
>
> (ENB 941)

A common theme within the focused programmes is that students are expected to reflect upon their own beliefs and attitudes and to challenge them. This emphasis is apparent in some of the mental health and learning disability programmes but was not explicit elsewhere. Some of the curricula stress that the process of ageing should be seen in a more positive light, for example looking at the advantages and achievements of being older rather than focusing solely on the negative aspects of the ageing process:

> *Within this course emphasis is placed on the abilities and gains in later life as well as acknowledging the problems of growing old.* (ENB 941*)*

Some curricula mention the need to empower older people. However, this term is not defined, nor are strategies for achieving patient and client empowerment clearly characterised.

4.3.2 Course aims and objectives

The curricula vary in length and breadth of detail in relation to stated aims and objectives. However, again a number of commonalties could be discerned across the range of educational programmes. The pre-registration programmes aim broadly to produce practitioners who are competent, responsible, accountable, flexible, knowledgeable, professionally and politically aware and committed to continuing education, all in a range of care settings. Some programmes identify objectives which relate specifically to autonomy and independence: for example

> *to produce a competent nurse who can respond to changing health care needs,* ***consumer demands*** *and technical innovations.* (our emphasis)
> (CFP)

> *to fulfil the role of a health educator facilitating clients to reach informed decisions about their health.* (Adult Branch)

> *to understand the essential need to involve carers and users of mental health services in all aspects of the care process.* (Mental Health Branch)

> *to work in partnership with individuals to enable self-determination, maximising their autonomy and rights.* (Mental Health Branch)

However, such consumer-oriented objectives are in the minority within the pre-registration curricula reviewed. The community focused post-registration programmes also vary in the extent to which they make the ability to develop partnerships with patients and clients an explicit objective. Again there is more emphasis on the need to develop the capacity to collaborate with other agencies and professionals than with clients. A minority of programmes identify community empowerment and development as an objective:

> *(The course member should)...empower individuals, their carers, families and groups to influence and use available services, information and skills to the full and act as advocate where appropriate,..... (and) support and empower individuals, families and communities to take appropriate action to influence health care and health promotional activities by means of a community development approach.*
> (Diploma in Health Visiting)

Few curricula specify the dimensions of autonomy and independence identified within the current research within learning objectives. One exception suggests that course members should be able to:

> *...identify key values underpinning sensitive care, equity, respect, dignity, democracy, empowerment and choice.* (Diploma in Health Visiting)

Several curricula suggest that content would be underpinned by the *Ottawa Charter for Health Promotion*, focusing on the process of enabling people to increase control over and improve their health. However, overall the programme objectives and learning outcomes for the community focused courses are insufficiently explicit about either the need to recognise the specific needs of older people, or more generally to promote patient/client autonomy, to suggest that these form important goals.

Many commonalties were found in the aims, objectives and learning outcomes for the focused programmes (ENB 941 and 298). All aim to some extent to enable nurse practitioners to study recent developments in the care of older people based on current research and thereby to update professional knowledge and practice. All the curricula reviewed seek to promote specialist nursing in relation to the care of older people. This involves nurses becoming competent in assessing, planning, delivering and evaluating specialist, individualised packages of care which include involving the relatives of the patient/client.

> *The nurse needs to learn how to enable elderly people to achieve and maintain their own lifestyle as far as possible and, where this is not feasible, to provide optimum care.* (ENB 941)

The specialist curricula appear to suggest that the key to nurses promoting independence for older people is through the promotion of nurse autonomy within a multi-agency approach, that is for a nurse to work as a member of a team. Objectives include self-development, updating of knowledge and professional skills and their application, developing an enquiring, critical and reflective approach and sharing of knowledge and ideas among students. The aim of the pre-registration programmes that nurses should develop an awareness of current policy trends, for example mental health legislation and its effect on older people as individuals, is further developed within the focused curricula to suggest that this could lead to nurses advocating for changes in policy in relation to the care of older people.

Finally the focused courses aim to give students all round knowledge in gerontological theory, ethics, communication, maintenance of health, self-help strategies and rehabilitation, as well as aspects of care in relation to factors such as environment and risk.

4.3.3 Design and content

Analysis of the course curricula revealed no consistent pattern in content relating to the promotion of patient/client autonomy and independence.

Pre-registration programmes are designed mainly in modular form with related clinical placements. Several approaches to the inclusion of content relating to the care of older people were identified: some programmes include modules on the care of older people within **either** the common foundation programme **or** adult/mental health branches, others include modules in **both** the common foundation programme **and** adult/mental health branches. In other programmes a life span approach is used: alternatively levels of care provide a framework , that is: primary care, secondary care and tertiary care, with more emphasis on the needs of older people in the latter. In most cases, care in relation to the older person features within modules in nursing, biological sciences, behavioural sciences and ethics. The dimensions of autonomy and independence feature to some extent in all these types of design.

Within learning disabilities branches, specific content relating to older people appears more limited. However, the principles of promoting autonomy and independence, partnership with clients, empowerment, advocacy and risk-taking are threaded throughout each curriculum and applied to any individual with learning disabilities.

With the exception of the mental health and learning disabilities branches, the concepts which are most strikingly absent from the curriculum documentation are partnership with the client/patient and risk. Partnership is often documented as a course value overall and appears in the philosophy statement but its achievement is rarely translated explicitly into the content. Some of the more recently validated courses mention risk assessment or management but do not appear to relate these to risk taking within nursing practice.

Ethics Specific content relating to ethics is found in all curricula. In most documents ethics is either a module or a sub-unit within a module. However the exploration of ethical issues is not confined to these modules alone and topics of a moral and/or legal nature are featured within modules covering professional issues, biology, sociology, social policy and psychology.

In relation to specific content, most pre-registration programmes cover the basic principles of philosophical and moral thought such as utilitarianism and deontology. These are then extended to consider concepts such as autonomy, paternalism, beneficence, respect, informed consent, confidentiality, control, duty and rights. Most documents suggest a consideration of ethical dilemmas in nursing care. The Code of Professional Conduct (UKCC 1992) is cited frequently.

Specific application of ethics to the care of older people is demonstrated in about half of the curricula reviewed (non-focused courses). One Adult Branch programme identifies the following learning outcomes:

> *To identify the ethical and moral dilemmas associated with the client group e.g. euthanasia, quality of life years, resuscitation, medical intervention and to explore their own emotions regarding the ethical and moral dilemmas which may arise.*

The community-based post-registration programmes are mostly characterised by core modules and options. Again, some programmes adopt a life-span approach.

All curricula reflect the dimensions of interest of the current study within the specified programme content to some extent. However, the detail in relation to each dimension varies considerably. This is illustrated by examples of two programmes leading to a professional qualification in district nursing or health visiting. Both programmes involve core modules together with specialist modules in either district nursing or health visiting. Figure 4.1 identifies the specific content relating to the dimensions of interest for both the core and specialist modules.

Only one of the community programmes examined in detail (Core module for Diploma in District Nursing/Diploma in Health Visiting) includes a specific module on the needs of older people. Entitled *'Perspectives of Ageing'*, this thirty-hour module appears to cover a range of content relevant to the promotion of autonomy and independence (Figure 4.2)

The documentation for the focused post-registration programmes (ENB 941 and 298) suggests variation in the emphasis and depth afforded to different topics. Nevertheless the following themes can be discerned within most curricula:

- the ageing process
- health promotion
- health problems (mental and physical)
- policy developments (professional and social).

The ageing process is consistently featured in relation to the social, physical, psychological and cultural needs of older people. Attitudes are examined, both in relation to older peoples' attitudes to ageing and the attitudes of course members and society in general.

A wide range of topics are associated with health promotion. These include preventive health care, rehabilitation, medication and social care. However, the emphasis varies between programmes. The majority of the ENB 941 programmes feature content on communication, covering both interpersonal skills and an understanding of sensory

Figure 4.1 Content for programmes leading to professional qualification in district nursing or health visiting relating to dimensions of autonomy/independence

Programme A	Programme B
Health Psychology-Interpersonal skills - non-verbal communication, questioning, listening, personality assessment self-disclosure and social skills Communication process - individual and group decision-making skills, conformity, modelling, behaviour modification Attitudes and Behaviour - Attitude formation, attribution theories, non-compliance. Models of health behaviour. Health professional and teamwork. Social Policy and Health Care Provision-Social Policy. Community Care Policy - Policy initiatives in relation to Care in the Community. Social Aspects of Health and Disease-Health for All - Year 2000 Professional Studies-Professional Code of Conduct. Accountability and quality assurance. Sociological Perspectives in Primary Health Care- Encounters between clients and health professionals: expectations and problems in health care. Professions as social control agents. The nature of control. The problem of control. The limits of control. The sociological critique of professional control. Types of professional intervention. Ethics of intervention. Outcomes of intervention. The iatrogenesis thesis. The dependency thesis. The advocacy thesis. The unintended consequences of intervention thesis. The consumer and evaluation. Social policy- ageing in family and community. The law relating to wills and probate. The law relating to the mentally disordered elderly patient and the compulsory routes into care. The law relating to power of attorney, enduring power of attorney and the Court of Protection. Economics- Reality of Choice -Participatory/collaborative opportunities. Politics in Primary Health Care- Power, authority and freedom - Power bases in Primary Health Care. Autonomy and acceptability Balance of power and the consumer - Models of service provision. Motivations for service provision. Weaknesses of the consumer. Epidemiology and Community Health- Notion of empowerment and health. Demographic Trends in Primary Health Care - Age/gender distribution. Clients Perceptions of Health Knowledge and beliefs of health Perceptions on intervention Lay satisfaction with care Professional v self care. Mental Health- Normal and abnormal mental changes in the elderly. People with Learning Difficulties- Stigma and stereotyping. Reversing the impact of institutionalisation. Research and Information Technology-Confidentiality of records, data protection act. Health Promotion- Self-Empowerment Model Communication skills Health Illness Continuum or Adaptation in the Life Cycle- Shared learning, health and ageing. Historical perspectives of ageing. Ageing and the social context. Theories of ageing. Patterns of ageing. Physiological theories and physical/physiological changes Disorders of ageing Organisation of the services Care in institutional settings Culture perspectives on ageing Screening and surveillance Self care and health in old age The roll of the specialist as a change agent. Innovation and change Health Psychology - Compliance/Adherence - Models of health behaviour built upon Module 1, focus on control, conflict theory, factors influencing compliance, factors reducing non- compliance. Old age, intellectual decline reversal, memory and planning problems; social isolation, disengagement and activity theories; the role of the social networks in the community	Professional issues - Ethics of the profession and importance to patient; legal position of the patient/client/consumer and the significance of the ethical dimension for professional accountability and confidentiality, concepts of freedom of choice. Psychology and communication skills : the holistic model of health care, communication, individualised care, self determination, therapeutic relationship, information giving, provision of individualised care, caring for elderly people: physiological, psychological changes of old age, perception, attention, memory, communicating with elderly people, dementia, RO, methods of caring for elderly people, active elderly - helping people adjust to retirement, abuse of elderly. Sociology and social policy- rights and responsibilities. Health promotion / Epidemiology - opportunities for the promotion of health. Counselling - importance of respect, empathy, genuineness, person centred philosophy approach.

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Figure 4.2 Module content 'Perspectives on Ageing ' (Diploma in Health Visiting/District Nursing)

Implications of being old in today's society
definitions; research; statistics; demographic changes;
broad overview of the programme

Social aspects
privileges and problems; attitudes of society; self-esteem; sexuality

Care in the Community
Choice and options; residential vs home care; regulations/control/evaluation of services

Psychological aspects
Theories of ageing; living with others; family and friends; thinking and remembering; feeling and doing

Physical aspects
Effects of ageing on physiological function; special reference to physical activity; sensory changes

Physical aspects
Identifying health needs/assessing health risks; screening hypothermia; safety factors/hazards in the home

Physical aspects
Drugs and the elderly

Physical aspects
Nutrition in the elderly

Mental Health
Alzheimer's disease

Mental Health
Depression; isolation

Coping at home
Needs of carers; chronic illness

Ethnic minorities
Cultural exploration of the needs of the elderly from ethnic minority groups

Concept of Loss for the elderly
Physical; social; psychological factors

Promoting Health
Prevention; exercise and rehabilitation

Helping elderly people make health choices/motivation for maintaining good health/effects of current policies on choices for the elderly problems. Only three courses specify content in relation to the empowerment of older people. Overall the majority of courses identify environmental issues such as housing, and leisure activities as relevant for the health of older people.

Assessment and evaluation are evident as core themes in slightly more than half of the programmes. Surprisingly, an emphasis on the need for a multi-disciplinary approach to the care of older people is apparent in the content of only half of the ENB 941 courses. One of the most common features in the ENB 298 and combined courses (ENB 941 and 298) is the promotion of advocacy. Social and psychological aspects of health problems are considered in relation to decision making and family support in approximately half of the courses. Most curricula include mention of ethical issues linked to care around the time of death such as living wills and euthanasia.

Content in relation to policy developments includes reference to social policies such as the NHS Patients' Charter (mentioned in two-thirds of the curricula) and to professional policy such as the Scope of Professional Practice (UKCC 1992). The named-nurse initiative is only mentioned specifically in one document although individualised care features in half of the programmes. The implications of the advent of consumerism within the NHS and the increasing role of voluntary agencies both feature widely.

To conclude, it appears that there is considerable variation across the programmes considered in the quantity and depth of material relating to the promotion of autonomy and independence for older people.

4.3.4 Teaching and learning strategies

All the course documents suggest that a wide range of teaching and learning strategies are used. These include: lectures, seminars, discussions, group work, micro teaching, brainstorming, team teaching, experiential learning, role play, computer assisted learning, skills practice and activities, tutorials, learning contracts, learning action groups, games, diaries, video and media, relaxation techniques, critical analysis, critical incidents, case studies, learning packs, clinical supervision, nursing research reports, reflection groups, simulation, workshops and laboratory work.

From the curricula documentation, it was impossible to identify specific strategies used to enable course members to develop the skills necessary to promote autonomy and independence for the older person. However a number of strategies for demonstrating links between theory and practice could be discerned. These included:
concurrent practice/field work enabling students to apply theoretical perspectives; encouraging students to critique practice within placement settings; use of reflection sessions/groups; and developing action plans for changing practice. A minority of post registration programmes identify a process of negotiation between teaching staff, course members and practice managers aimed at enabling course members to apply knowledge gained within their own practice area. The assessment strategy also asks for course members to relate their experience to theoretical principles and knowledge.

All the curricula reviewed advocate a student-centred, androgogical approach to teaching and learning. However the emphasis placed upon this dimension varies and is perhaps understandably more apparent in the post-registration programmes; for example:

> *development of individual profiles at commencement of course, assessment of need made for each individual course member in order to encourage personal development.* (ENB 812)

> *the onus will be on the student in conjunction with the assessor to identify learning needs. Both will be encouraged to devise a learning contract based upon the appraisal assessment schedule provided.*
> (Diploma in Practice Nursing)

> *as the programme is student-centred the individual's strengths and needs partly determine the programme.* (Health Visiting)

Similar teaching and learning strategies are employed within both the ENB 941 and ENB 298 courses. Again an androgogical, individualised approach to teaching and learning is apparent, with the most common strategies being theory concurrent with practice, reflection, problem solving approaches to individualised care delivery and use of prior experience.

> *It is accepted adult learning theory that adult learners expect, and should be consulted about, their own learning; that adult learners have accumulated a reservoir of experience, that it is a substantial resource to be used in the learning process and that the experience of participants must be used and built upon if learning is to be applied in the work setting.*
>
> (ENB 941)

4.3.5 Assessment

Assessment of theory and practice within pre-registration programmes is commonly linked to the overall curriculum model and philosophy. The assessment of theory is designed to show that the course member is competent in achieving the learning outcomes for each module or group of modules and to fulfil the criteria set by the UKCC in order to register as a nurse. Assessment is continuous and, depending on the type of assessment, is carried out by the teacher/lecturer, peers and/or the student themselves.

Types of assessment are varied and include: essays (seen and unseen), examinations (seen and unseen), seminar presentations, written presentations, case studies, neighbourhood studies, critical incidents, project work, portfolios, learning journals/ reflective diaries, learning contracts, health promotion packages, taped interviews with critical review, literature reviews and research critique.

The opportunity to negotiate the focus of an assignment is common where assessment is based upon a case study, portfolio, project, dissertation or health promotion package. More often, a limited range of topics (such as a choice of essay titles) are made available. In almost all the curricula examined, the use of assessment to bridge the theory-practice gap is made explicit for example by asking course members to relate their experiences to theory and vice versa. One example is the development of a health promotion package which the course member then implements and subsequently evaluates (Adult branch).

Assessment of practice is continuous within the pre-registration programmes and the expected level of competency increases as experience is gained. Competencies are assessed using various scales and again as in many other areas of the curricula there is

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very little consistency. The assessor for practice is always a qualified registered nurse who may be required to hold a teaching qualification e.g. City and Guilds 730/6 or the ENB Course 998/997. The student also assesses their own practice.

Assessment strategies within the post-registration community programmes employs a range of approaches. Two curricula specifically mentioned the need to demonstrate an ability to work in partnership. One health visiting programme for example stressed the need to show evidence of partnership within a health promotion project, through the use of negotiating skills.

Within the focused programmes a combination of self assessment and peer assessment is apparent. However, a minority of these programmes use a learning contract or a personalised development strategy as a tool for negotiation between the student and tutor. Essays and other written assignments are sometimes negotiable One ENB 298 programme includes a group project which would encourage negotiation between the members of the group.

There is an on-going debate about the use of reflective diaries in assessment, as they are felt to be very personal to the student (Cameron and Mitchell 1993). However, seven courses use a journal or diary, and two specify reflective practice as part of the course assessment. Other methods of assessment include examinations and care studies.

Course members are involved to some extent in their assessment in most curricula. However, of the curricula reviewed in the study, only one mentions the direct involvement of patients. This is an ENB 298 curriculum which involves patients in the assessment process by seeking their permission for the course member to submit a case study on their progress and to verify the accuracy of the student's documentation regarding their case:

> *The client will share in the assessment by agreeing to partake and verify the accuracy of documentation.* (ENB 298)

On the whole no clear pattern of either nurse or patient participation emerges in the assessment process. However, the courses do incorporate diverse assessment strategies.

4.3.6 General Points.

If curriculum documentation is to guide teachers in the delivery of a programme, then the language needs to be clear and unambiguous. We found numerous examples of terminology which we found impossible to code because the meaning was obscured by imprecise expression and unnecessary jargon; for example:

> *Human care consists of transpersonal human to human attempts to protect, enhance and preserve humanity by helping a person find meaning in illness, suffering, pain and existence, to help others gain self-knowledge, control and self healing wherein a sense of inner harmony is restored regardless of the external circumstances*
> (Diploma in Health Visiting)

Additionally, we found a lack of coherence and logical structure within some documents, with no clear relationship between course philosophy, objectives and content.

Use of the phrase 'the elderly' is common and was noted in more than half the curricula. Use of this phrase may have negative connotations, implying that older people are an homogenous group. Phrases such as 'older people' or 'older persons' may imply a more individualised and positive image and are preferred by older people themselves (Walker 1993).

A number of documents suggested a gender bias; for example:

> *A broad overall theme was identified by the course management team - 'Well Man through to Coping Man' - and from this the individual weekly themes were identified.* (ENB 941)

Another document refers to the nurse throughout as 'she', without justification or explanation. The guidelines for the validation of courses produced by the ENB currently offer no guidance on appropriate terminology.

4.4 Summary of Phase I findings

- We were able to identify content relating to most of the dimensions of interest within most curricula. Exceptions were the notion of working in partnership with patients/clients/significant others and the management of risk. Although participation in care features as a key value within many course philosophies, this is often not made explicit within course content. Where risk is mentioned this is generally not specifically related to decision-making in relation to the need to balance an individual's autonomy with an acceptable degree of risk.

- There was a lack of any consistent pattern in relation to the notions of autonomy and independence within curriculum documents. More generally, there were few examples of innovative thinking in relation to the precepts or goals of nursing beyond traditional care aims.

- We found a lack of coherence and logical structure within some curriculum documents, with no clear relationship between course philosophy, objectives and content.

- Apart from the focused courses, few curricula identify the dimensions of interest applied to older people as specific content. Rather the dimensions form 'threads' throughout the curriculum, without explicit reference to how course members might be encouraged to apply these ideas in caring for older people.

- We found very little evidence that older people are involved in developing programmes or teaching students. Where this did happen, it was generally via advocates and special interest groups rather than service users themselves. Only one of the programmes examined involved patients in the assessment process in the validation of students work.

- Although it appears that practitioners are given opportunities to participate in programme development and delivery, many course leaders identified barriers to collaboration, for example pressures of work and the speed at which curricula need to be developed .

- Course leaders were keen to make the programmes more practice focused and to strengthen the links between theory and practice, for example by conducting more tutorials in clinical practice settings.

- Those programmes which appeared to focus more explicitly upon the needs of older people for self-determination shared the following characteristics:
    an emphasis on challenging attitudes and stereotypes;
    content specifically aimed at developing the skills to challenge and change practice;
    participation as a theme running throughout.

- These characteristics were commonly more apparent within the mental health programmes (branch and ENB 812) and reflected the increased emphasis on the development of advanced interpersonal skills.

- We found some problems with terminology. Use of the phrase 'the elderly' is common and was noted in more than half the curricula. A number of documents suggested a gender bias.

Chapter 5: National Survey of Continuing Care Settings

5.1 Methods

5.1.1 Overview Phase II of the study involved a survey of continuing care facilities in three Health Regions in England. The main intention was to determine whether there is a relationship between the educational preparation of nursing staff in continuing care settings and the quality of life of the residents within those settings. A self-completion questionnaire was designed to establish the educational preparation of nursing staff working in continuing care facilities. The questionnaire, addressed to the most senior nurse within each facility, included a previously validated measure of resident autonomy. This allowed an exploration of associations between the educational preparation of staff and an indicator of quality of care.

5.1.2 Sample Three Health Regions were purposively selected to cover urban and rural populations. District Health Authorities within each Region were identified and a list of all nursing homes within each authority area was obtained from the Nursing Homes Inspectorate (Region 1 N= 469, Region 2 N = 695 and Region 3 N = 699).

A random sample of 20 homes from each region was initially identified for pilot work, in order to establish educational spread and to determine the size of the final sample. A further 976 homes were randomly sampled from the lists and a self completion questionnaire was addressed to the manager of each home with a covering letter assuring confidentiality (Appendix III). The questionnaire was addressed to the most senior nurse in charge of each facility. An inclusion criterion was that the respondent had contact with the day to day care of residents. The random sample included large and small, rural and urban, private, private with NHS beds and voluntary homes. The sample also included homes with specific provision for groups such as the elderly mentally ill and those with specific physical disabilities, for example visual impairment.

During pilot work, the research team became aware of another research project focusing on the educational needs of nurses working in nursing homes, which was also sending self-completion questionnaires to homes within three health authorities included in our sample (Morrell et al 1995). These three health authorities were subsequently excluded from the sample in order to avoid the problem of over-researching. The findings of this study contributed to the discussion within this report (Chapter 9).

5.1.3 Continuing Care Wards in the National Health Service

It was our original intention to identify continuing care facilities in hospital settings as well as in the community. However, this study was conducted at a time when the balance between the provision of long-term institutional care for elderly people by the state and private sector had largely shifted to the private sector, continuing a process which began in the 1980's. NHS wards for long-term patients, the bedrock of geriatric medical services in previous decades had all but disappeared, although our enquiries to officers in the Health Regions and Districts revealed a lack of information about the presence or absence of these facilities.

Our intention to survey the quality of care and educational preparation of nursing staff in both NHS long-term care wards and private nursing homes was therefore frustrated and we had to focus on the private nursing homes alone. Ironically, at the time of writing this Final Report, there are signs of a change of direction in both the financing and provision of long-term care for older people. Following a critical report by the Health Service Ombudsman (Parliamentary Commissioner for the Health Services 1994), Health Authorities are implementing new guidelines from the Department of Health (DOH 1995) which make provision for Health Authorities to contribute top-up funds for the health component of individual packages of long-term care for patients living in the community and in nursing and residential homes. In addition, patients are being identified as requiring long-term hospital or nursing home care, where the Health Authority has a responsibility to pay all the costs of their care. Implementation of these guidelines may lead to the return of some geriatric long-term care wards where they had disappeared from the health service.

5.1.4 Ethical issues Ethical approval was sought from local research ethics committees in each of the relevant health authorities early on in the study when it was thought that hospital wards would be included. All approved the study. The covering letter included with the questionnaire stressed the confidential nature of the research. Return of a completed questionnaire was assumed to imply consent to participation in the study.

5.1.5 Questionnaire Design The questionnaire was designed by the research team and included an instrument designed by one member of the team to determine an autonomy score for each nursing home (Challiner et al. 1994). The questionnaire was divided into three sections:

Section 1 was designed in order to obtain information about the person completing the questionnaire. The covering letter stated that this should be the senior nurse in charge of the direct care of residents.

Section 2 asked for information regarding other nursing staff in the home. These questions were designed to provide data on the number and qualifications of full and part-time staff, the ratio of qualified to unqualified staff and the nature of any on-going continuing education.

Section 3 asked for information about the type of residents and normal practices within the home. Questions were also included to provide an indicator of the dependency of residents within each home. This final section included the autonomy scale.

5.1.6 Design of Instrument: the Autonomy Scale

The autonomy scale used in this study has its origins in the work of Goffman (1961) who described the block treatment and strict routine designed to fulfill the official aims of an institution which lead to the loss of autonomy of individuals living in institutional settings. Goffman also showed the importance of staff attitudes in shaping the regime. Most observers of long-term institutions which care for older people in the UK have found these negative features of institutional life (Townsend 1962, Clough 1981, Booth 1985, Sinclair 1988).

Peace et al. (1979) developed an instrument for measuring the quality of care of older people in residential homes, which was subsequently used to describe the quality of care in a national survey of residential homes (Willcocks et al. 1982). The instrument was multi-dimensional, including measures of disability and perceived well-being of residents, staff morale, regime and environment. The measures of regime covered domains of choice, privacy, engagement, involvement, and resident-orientated policies. The environment was assessed according to the extent to which it promoted resident influence (for example whether residents were able to keep their own furniture, whether they had control over appliances). High scores on these measures reflect the extent to which a residential home had counteracted the negative effects of institutionalisation by promoting the autonomy of residents.

The methodology was recommended for amendment for use in other institutional settings for older people. Philp et al (1989) developed and validated the methodology for use in nursing homes and long-term care wards, going on to compare quality of life and quality of care in nursing homes and long-term care wards of older people in a small survey in a Scottish city (Philp et al.1991). The questionnaire contained 59 items about regime and environment. In a subsequent study (Philp et al. 1991) 28 cognitively-intact residents in 12 long-term care establishments, and 22 of their nurses were asked about the appropriateness of each item for their circumstances, and 26 items were favoured by a majority of both staff and residents (staff supported all items favoured by residents). Each measure of quality applied to at least one establishment and did not apply to at least one other establishment, suggesting the potential to raise standards of care.

A short questionnaire based on the items favoured by residents was used in a postal survey in Southampton (Challiner et al. 1994). The 26 items were reduced to 18 to eliminate duplication and to streamline the questionnaire. The questionnaire was posted to officers-in-charge of 205 long-stay residential, nursing and local authority homes and 11 long-stay hospital wards in the Southampton District. Follow-up inspections and unannounced interviews with members of staff were conducted in a random sample of establishments. There was a 94% response rate to the postal questionnaire, with a high reliability co-efficient between survey and inspection data ($r=0.88$). There were significant differences in scores between sectors ($p<0.001$) and a correlation between average dependency of residents and scores ($r=0.48$). The scores for the nursing home sector had a range of 10 (low autonomy) to 18 (high autonomy), mean 14.31, SD 1.86.

We selected this 18 item scale as our instrument for measuring autonomy because of its established properties of criterion, construct, content and discriminant validity, reliability and high response rate when used in the nursing home sector.

5.1.7 Pilot Study A purposive sample of twenty nursing homes from each region was selected to include all home types. The intention of the first pilot was to test the wording, structure and time taken for completion of the questionnaire. An evaluation sheet was included with the covering letter and questionnaire in order for comments to be made by the respondent on these items. Comments were also sought from members of the Steering Group and from the Chief Executive of the Quality Care and Nursing Home Advice Service. Minor adjustments were made to the questionnaire as a result.

A total of 976 questionnaires were then posted for the main study. A reminder letter and a second copy of the questionnaire were posted to non-responders two weeks after the date stated for return.

5.2 Findings

5.2.1 Response Rate A total of 976 questionnaires were posted and 676 returned representing a response rate of 69%. Eleven questionnaires were incomplete for various reasons, for example the home was no longer in existence, the person to whom the questionnaire was addressed no longer worked at the home or the home was no longer caring for older people (this was sometimes not identified on the lists sent by DHA's). Five questionnaires were sent after the final cut off point for return and these have not been included in the analysis. The corrected response rate was therefore 68.4% (n= 660).

5.2.2 Characteristics of respondent (senior nurse within each home)

The main characteristics of respondents were as follows:

- ninety-eight responses (15%) were from persons who owned the nursing home
- the average age of respondents was 44.8 years (range 23 - 74 years)
- average length of time in post was just over three years (eight years for those respondents who owned the establishment (additional tables in Appendix V)

Qualifications of respondents are presented in table 5.1. Ninety per cent of the most senior nurses within the facility possessed the Registered General Nurse/State Registered Nurse qualification, with 19% holding the ENB 941 qualification and 2% the ENB 298 qualification. These qualifications are not mutually exclusive.

When asked if they were undertaking any educational programmes related to their work, 273 (41%) respondents stated that they were, with 269 of these identifying a specific course, or combination of courses (Table 5.2). Most (33% n=90) were taking NVQ and City and Guild programmes, mainly assessor's courses for NVQ. Six per cent were undertaking ENB courses.

Five per cent of respondents were in the process of completing two educational programmes.

5.2.3 Educational preparation of other nursing staff within the home

Table 5.3 illustrates the staffing composition of nursing homes. The ranges are influenced by a small number of very large nursing homes within the sample.

Table 5.1 *Qualifications of respondents (senior nurse within each home)*

Qualification	Respondents (%)
RGN/SRN	90
ENB 941	19
Registered Mental Nurse	17
Community Nursing	11
Other Degree	9
Enrolled Nurse	9
Degree in Nursing	2
ENB 298	2
TOTAL	**n = 660**

Table 5.2 *Type of educational program being undertaken by respondent (senior nurse within the home).*

Type of educational program	Respondents (%)
NVQ/C&G	33
Study Courses	22
Degree/Diploma	15
ENB Course	6
Other	12
Combinations of two the above	12
TOTAL	**n = 269**

Table 5.3 ***Qualifications of nursing staff within the home***

Type of staff	Mean	Median	Range
1st Level Nurses (RGN/RMN)	8.1	8	1-72
2nd Level Nurses (Enrolled Nurse)	3.5	3	1-40
Health care assistants	22.0	20	1-81

Table 5.4 highlights the distribution of staffing qualifications across the homes. The most frequent qualification held was a RGN/SRN qualification, with an average of 7.3 staff per home (range -66 staff). There were an average of 3.1 staff with an enrolled nurse qualification, though only 0.6 staff with an ENB 941 qualification (range 0-32 staff) and 0.1 staff with an ENB 298 qualification (range 0-8 staff).

Table 5.4 ***Qualifications held by qualified nurses in nursing homes***

Staff Member	Mean no of staff in each home	95% confidence interval	Median	Range
RGN/SRN	7.3	(7.0, 7.7)	7	0-66
Enrolled Nurse	3.1	(2.9, 3.3)	3	0-40
Reg Mental Nurse	1.2	(1.0, 1.4)	2	0-15
Degree in Nursing	0.1	(0.07, 0.13)	0	0-3
Other Degree	0.1	(0.07, 0.13)	0	0-7
ENB 941	0.6	(0.5, 0.7)	0	0-32
ENB 298	0.1	(0.005, 0.15)	0	0-8
Community Nursing (DN/HV)	0.4	(0.3, 0.5)	0	0-9

Table 5.5 ***Proportions of qualified nursing staff with each type of qualification employed within the home***

Qualification	**% qualified nursing staff employed**						
	0 %	**<20% %**	**<40% %**	**<60% %**	**<80% %**	**<100% %**	**TOTAL (n)**
RGN/SRN		3	6	27	32	27	**638**
Enrolled Nurse	14	26	38	18	3	1	**653**
Reg Mental Nurse	59	23	7	4	4	3	**651**
Degree in Nursing	87	10	<1				**655**
Other Degree	90	9	<1	<1			**655**
ENB 941	68	25	4	1	<1		**654**
ENB 298	92	6	<1	<1			**654**
Community Nursing (DN/HV)	73	24	3				**655**

The proportions of first level, second level and unqualified staff as a percentage of all staff employed are shown in Table 5.6

More than seventy per cent of homes have staffing complements with less than 30% of posts occupied by first level nurses. Conversely, seventy-five per cent of homes have a staffing establishment comprising at least 60% nursing auxiliaries and health care assistants.

Tables 5.7 and 5.8 indicate the number of nursing auxiliaries and health care assistants holding, and currently undertaking, National Vocational Qualifications (NVQs). These figures suggest that opportunities for unqualified staff to undertake vocational training are infrequent.

Table 5.6 *Proportions of first level, second level and unqualified staff as a percentage of all staff employed*

% of all staff employed (nursing)	1st level (RGN/RMN) %	2nd level (EN) %	Unqualified (Nursing %
0	<1	14	2
<10	<1	46	0
<20	27	33	<1
<30	45	5	<1
<40	21	<1	<1
<50	3	<1	4
<60	1	0	17
<70	<1	<1	45
<80	<1		26
<90	<1	0	3
<100	<1	0	<1
TOTAL	n=660	n=660	n=660

Table 5.7 *Number of unqualified staff employed within the home who hold NVQ qualifications*

Level	Mean	95% confidence interval	Range
Level 1	0.4	(0.3, 0.5)	0-20
Level 2	1.9	(1.7, 2.1)	0-25
Level 3	0.2	(0.15, 0.35)	0-6

Table 5.8 *Number of unqualified staff within the home currently undertaking NVQ qualifications*

Level	Mean	95% confidence interval	Range
Level 1	0.2	(0.1, 0.3)	0-15
Level 2	2.9	(2.6, 3.2)	0-22
Level 3	0.5	(0.4, 0.5)	0-17

Contact with educational centres Respondents were asked about contact with local schools and colleges of nursing, in particular whether the home provided placements for nursing students. Thirty-seven per cent (n=242) replied that they did provide placements however the survey did not produce information on the nature of these placements. Information on the type and frequency of contact with local schools and colleges of nursing is presented in Tables 5.9. and 5.10. Thirty-one per cent of respondents indicated that the home had no contact with schools and colleges of nursing. In relation to the frequency of contact, over 70% of those who replied (n=420) suggested that contact was infrequent or non-existent.

Table 5.9. *Type of contact between homes and local schools/colleges of nursing*

Type of contact	Homes (%)
Information via letter/phone	35.0
Staff attend study days/courses	12.2
No contact	31.0
TOTAL	**n=583**

Table 5.10 *Frequency of contact between homes and local schools/colleges of nursing*

Frequency of contact	Homes (%)
Frequent/regular	28.7
Infrequent/very little	40.4
None	31.0
TOTAL	**n=587**

5.2.4 Characteristics of the home

The majority of the sample, not surprisingly, comprise private nursing homes with 93% of responses from such facilities, 5% from the voluntary sector and 2% from private homes with NHS beds. The mean number of beds ranged from 33.7 in the voluntary sector to 39.0 in the private nursing homes (including one facility of 424 beds). Mean occupancy is high, and ranging from 89% in private homes to 97% in the voluntary sector. Further details and additional information in relation to the dependency needs of residents is included in Appendix V.

5.2.5 Exploration of the relationship between the educational preparation of staff and resident autonomy

Two scales have been used as indicators of resident autonomy: the 18 point scale previously described (Challiner et al 1994), and a subset of eight items drawn from the eighteen point scale. Both scales assume equal weighting between the items constituting the components of the overall score.

18 point scale: This scale includes 18 items, each of which scores 1 for a 'yes' response, and 0 for a 'no' response. Frequencies of responses to individual items are shown in Table 5.11.

Within our sample of nursing homes, the distribution of autonomy scores (ranging from 0 = low autonomy, through to 18 = high autonomy) is heavily skewed towards the 'autonomous' end of the distribution. The mean autonomy score is 15.2 (n=593).

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8 point scale: This scale could be termed a 'nursing dependent' scale and is based on a subset of eight items from the 18 item scale (starred items in Table 5.15). The eight questions were selected as indicators of aspects of resident autonomy over which the nursing staff could exert more control, rather than characteristics of the environment which would be more difficult to alter. The distribution of scores is heavily skewed towards the autonomous end of the distribution, whereby high resident autonomy would be represented by a score of 8. However, the mean score for this scale was 7.7 (n=633) and about 98% of responses scored either 7 or 8, thus the distribution is highly skewed towards an autonomous sample. Furthermore, much of the variability within responses to this scale is explained by one item.

Table 5.11 *Responses to individual items on the 18 item autonomy scale*

Item	Respondents indicating 'yes'	
	n	%
Can residents use their bedrooms whenever they want? *	651	97
Can residents come and go outside the home? *	655	98
Are there separate toilets for men and women?	480	72
Are residents taught new skills *	495	74
Can residents go to bed when they wish? *	647	97
Are there both smoking and smoke free rooms?	479	75
Are there facilities for residents to lock away possessions?	375	56
Can residents have privacy when they wish? *	653	98
Are there facilities for residents to make telephone calls in private?	610	91
Is there a lounge with no television?	432	65
Are bedside lights provided?	629	94
Do all bedrooms have electrical sockets?	641	96
Is there a garden for residents to sit in?	647	97
Are mobile residents able to get into the garden unaided?	620	93
Is there a visitors' room	262	39
Are residents enocuraged to maintain self-care skills? *	652	98
Do staff encourage residents to help themselves? *	652	98
Are staff encouraged to sit and talk to residents? *	649	97
TOTAL	660	

A composite educational score was derived from the following proportions:

A = % total staff with first and second level qualifications -

B = % total qualified staff employed with at least one additional qualification

C = % total unqualified staff employed with NVQs (all levels)

D = % total qualified staff undertaking continuing professional education

E = % total unqualified staff with NVQs

The composite score was calculated as Educational Score = (A + B + C + D + E) / 5 A potential limitation of this scale is that each of these five components assumes equal weighting. A means of determining appropriate weighting for each component was however beyond the remit of this work and could not be validated within the confines of this particular study. The mean educational score was 44.5, with a 95% confidence interval of 41.8 to 47.2 (n=615).

A variety of analyses were performed to investigate any associations between resident autonomy and the educational preparation of nursing staff. The following section concentrates upon analyses based upon chi-square tests of a series of cross-tabulations.

Several statistically significant associations ($p<0.05$) were detected, all of which require interpretation with caution when the distribution of the autonomy scores is considered:

- An association was detected between the 18-point scale and the composite educational score for the facility (Table 5.12)

- There is an association between the 8 point scale and the proportion of qualified staff undertaking educational programmes (where proportions are categorised as 0%, <25%, <50%, <75%, <100%) (Table 5.13)

- There was an association between nurse controlled resident autonomy and the frequency of contact with colleges/schools of nursing (Table 5.14)

Table 5.12 *Educational score of facility and resident autonomy score (18-item scale)*

Score on autonomy scale (18 = highest)	<25 %	<50 %	<75 %	<100 %	total n
11	79	21			14
12	40	55	5		20
13	51	47	2		57
14	38	61	1		87
15	35	61	3	1	114
16	31	62	5	2	130
17	27	71	1	1	103
18	29	56	15		34
TOTAL n	**201**	**335**	**20**	**4**	**560**
%	**36**	**60**	**4**	**<1**	**100**

x2 = 43.6 24DF p=0.00842

Table 5.13 *Proportion of qualified staff undertaking educational programmes and autonomy score (8-item scale)*

Score on autonomy scale (8 = highest)	Proportion of qualified staff undertaking educational programmes					
	O %	<25 %	<50 %	<75 %	<100 %	total n
6	31	15	46	7		13
7	46	30	14	4	12	132
8	39	37	14	7	3	449
TOTAL n	**240**	**211**	**86**	**37**	**20**	**594**
%	**40**	**36**	**14**	**6**	**4**	**100**

x2 = 20.57 8 DF p=0.00837

Table 5.14 *Contact with local schools/colleges of nursing and resident autonomy score (eight-item scale)*

Score on autonomy scale (8 = highest)	Contact with Schools/Colleges of nursing			
	frequent/ regular %	infrequent %	none %	Total n
7 and below	21	33	46	24
8	31	43	26	76
TOTAL n	163	227	174	564
%	29	40	31	100

x2 = 19.5 2DF p=0.0006

No associations were detected between the proportion of unqualified staff currently undertaking educational programmes and resident autonomy, whether homes offered placements for nursing students and resident autonomy, and qualifications held by the senior nurse (other than RGN/RMN) and resident autonomy.

5.3. Summary of findings from Phase II

General points:

The findings of this survey describe the characteristics of a national sample of nursing homes and the educational preparation of nursing staff working within them. The research team had originally intended to compare nursing home provision with continuing care provision in NHS hospital wards: however, drastic reductions in NHS provision of continuing care resulted in a focus on nursing homes only. Quality of care as determined by a measure of resident autonomy would appear to be better than is widely perceived.

Educational preparation of most senior nurse within each facility:

- Ninety per cent of respondents held the RGN qualification and 18% the RMN qualification

- Only 19% of respondents held the ENB 941 (Short course in Nursing Elderly People). Just over 2% held the ENB 298 (Nursing Elderly People)

- Overall, 11% of respondents held a degree. Two per cent held a degree in nursing

- Forty-one per cent of respondents were undertaking an educational programme at the time of the survey but most of these were NVQ programmes. Fifteen per cent were undertaking a degree or diploma

Educational preparation of other nursing staff

- More than 75% of homes have a qualified to unqualified staffing ratio of less than 1:2
- Of qualified staff within each home an average 64% hold the RGN qualification, 27% the enrolled nurse qualification and 11% the RMN qualification.
- On average, less than 5% of all qualified staff within each home hold the ENB 941 qualification and less than 1% hold the 298. Less than 2% have a degree.
- In nearly half of all homes, less than 25% of qualified staff are currently undertaking educational programmes.
- An association was detected between the resident autonomy scale and the composite educational score for each facility

There was an association between the nurse-led autonomy scale and the proportion of qualified staff undertaking educational programmes.

Contact with local schools and colleges of nursing

- Thirty-seven per cent of homes provide placements for nursing students although 28% have no contact with local schools and colleges of nursing and 36% reported very little contact.
- There was an association between both measures of resident autonomy and the frequency of contact with colleges/schools of nursing.

A number of positive associations were found between several measures of education and resident autonomy. The positive association between the educational score for each facility and the eighteen item resident autonomy scale provides statistical support for our primary hypothesis that the educational preparation of nursing staff is associated with the promotion of autonomy of residents.

Chapter 6. Attempts to set up a randomised controlled trial to evaluate the ENB Course 941

6.1 Introduction

The aim of Phase III of the study was to determine the effects of the ENB Course 941 (Nursing Elderly People) on the knowledge, skills, attitudes and practice of nurses working in diverse hospital and community settings. Phase III was designed to test the following hypothesis: ***Nurses who have undertaken the ENB 941 Course (Nursing Elderly People) are more likely to promote autonomy and independence in their practice with older people than nurses who have not undertaken the programme.*** Our intention was to allocate course members at random to either an experimental or a control group from a list of potential nominees identified by nurse managers. The experimental group would then undertake the next available programme and the control group would be offered places on the following programme. Informed consent would be obtained from potential course members prior to random allocation. Figure 6.1 summarises the proposed research design and methods of Phase III at the outset of the study.

Figure 6.1 ***Proposed research design (Phase III)***

	Pre test	**Intervention**	**Post test**
Experimental Group	Questionnaire n>60 Structured non-participant observation n>30 (*sub sample*)	ENB 941	Questionnaire n>60 Structured non-participant observation n>30 (*sub sample*) Semi structured interviews with participants course teacher nurse manager
Control Group	Questionnaire n>60 Structured non-participant observation n>30		Questionnaire n>60 Structured non-participant observation n>30

Our original proposal was that both groups would complete structured questionnaires before and after the experimental group undertook the ENB 941 programme. A sub-sample of both groups would also be observed in practice before and after the introduction of the independent variable to the experimental group. Participants would be observed using a rating scale based upon work by Gilloran et al (1994) (see Chapter 7). Pre- and post-course questionnaires and observations would be complemented by brief semi-structured interviews with course members and their nurse manager and/or a colleague in the practice setting to explore their perceptions of the impact of the course on practice.

Due to a series of practical difficulties, it was not possible to implement the design as conceived within the original proposal. This chapter provides an account of the challenges faced by the research team in attempting to set up the RCT in a bid to inform the debate on approaches to the evaluation of education for practice.

6.2 Criteria for sample selection and recruitment

Centres offering the ENB Course 941 were identified with the help of the ENB's central office. At the beginning of the study, fifty centres in England were offering the programme. Eight centres in the Midlands and North of England were invited to participate in the study. The centres were selected using the following criteria:

- the centre is within a two hour travelling distance of Sheffield (to optimise the resource available in the project)
- the ENB 941 programme would be delivered within the period of time allocated for this phase of the project
- the curriculum was research-based (with reference to the review of the literature)
- nurses are recruited to the programme from a range of settings providing nursing care to older people

Two of the eight centres declined to participate at this stage. One centre submitted our proposal to their research ethics committee who denied the request due to the volume of ongoing research. The second centre declined due to '*...internal and external* *factors......creating circumstances not conducive to participation'.* Representatives of the research team met with the Principals and Course Leader of the remaining six centres. All six expressed interest in participating in the study and agreed to provide the research team with the names of the nurse managers who nominated candidates to the ENB 941 programme.

Subsequent to the meeting with representatives at one of the six centres, it emerged that the research team had been misinformed on the timing of the ENB 941 programme within this centre, which would actually fall outside the timescale of the project. At this stage, potential course members had already been approached by the research team. The 941 programme at another centre was modularised during the period of recruitment to the study, with the consequence that there was no longer a predetermined course completion date. Our only option was to exclude these centres from the study.

6.3 Outcome of recruitment exercise

Of the eight centres approached, four participated in the study. One centre (Centre A) was offered on three separate sites. Figure 6.2. includes details of the 941 programme at each centre

Figure 6.2 *Description of ENB 941 programmes at centres recruited to Phase III*

CENTRE	941 start date	941 start date	941 start date	No of Study Days	Over	Places
A1	April 96	August 96	Nov 96	22	18 wks	20
A2	April 96	July 96		22	18 wks	20
A3	April 96	July 96		22	18 wks	20
B	Jan 96	April 96		20	12 wks	15
C	Jan 96	Sept 96		12	25 wks	20
D	Jan 96	Sept 96		22	15 wks	15/20

6.4 Identifying the sample

A range of options for identifying potential course applicants were considered. The existence of a waiting list of applicants varied between centres but in no case was sufficiently long to generate an adequate sample to allow applicants to be randomly allocated to the next programme or the one following (our original intention). An alternative was to ask nurse managers to identify potential nominees to the programme.

Nurse managers nominating to the ENB 941 programme were identified via the course leader, the contracting officer for the School of Nursing and the application forms of nominees currently undertaking the programme. Where the NHS Trust maintained an elderly care directorate, identifying managers likely to nominate candidates was straightforward. In other Trusts elderly patients and clients were dispersed throughout the organisation within the general medical, surgical, orthopaedic and other clinical areas. Managers across the spectrum of health care directorates nominated staff to the ENB 941 programme.

Access to the nominees and therefore the generation of a potential sample relied, in the first instance, on the willingness of managers to participate. Each of the ENB 941 Course Leaders was contacted and asked for a list of the Nurse Managers who in the past had seconded individuals to the ENB 941 programme. Whilst all the Course Leaders agreed to provide the names of the Nurse Managers, gaining this information proved more difficult. The time period from the initial request to receiving the names ranged from one to ten weeks. By the time Centre D had provided the names of the nurse managers the seconding managers to this programme had already nominated candidates to the next intake. This negated the possibility of randomly allocating nominees to the next or following programme in this instance.

The difficulty in gaining the names of the nurse managers was problematic in relation to the limited timescale for the project. The ENB 941 programme had to be completed within three months of the close of the project to allow for data analysis and writing up of the final report. The longer it took to gain the names of the nurse managers, the less time the nominees would have to consider their potential involvement in the study. The loss of one centre because the nominees had been allocated to the next 941, meant that the sample was reduced, potentially by twenty nominees. If the nurse managers subscribing to the remaining three programmes declined to participate, or if they agreed to random allocation and the nominee did not, the sample size for the randomised controlled trial would have been reduced further.

6.5 Quasi - experimental design - an alternative approach

Part of the success of a randomised controlled trial rests with the sample size. Our preliminary investigations suggested that a randomised controlled trial might not be feasible within the context of this study and the research team began to consider alternative approaches. A quasi-experimental design would involve recruiting the sample from those already allocated to the forthcoming programmes, including centre D, and matching the nominee with another individual on specific criteria such as age, experience, qualifications and field of clinical practice. This would provide a matched sample to enable the effects of the programme to be explored.

The quasi-experiment is adopted when one of the three components of true experimental design (random allocation, control groups and manipulation of the independent variable) is not possible (Burns & Grove 1993). A quasi-experimental design provides a compromise within social settings, where the researcher may not be able to exercise complete control over the manipulation of variables.

> *True experimentation is the best design to use to predict causal relationships but it may be inappropriate for other forms of enquiry and research settings in health and human services.* (DePoy and Gitlin 1993)

Within a randomised controlled trial, threats to internal validity are controlled through the random assignment of subjects to the experimental and control group. Random allocation is the standard approach to maximising the probability of equivalence between the experimental and control groups (Campbell & Stanley 1963). A matched sample would be concomitant with a reduction in the internal validity of the research findings of this phase of the project. Mindful of this threat to internal validity if we were unable to proceed with the RCT, we carried out a telephone survey of nurse managers to determine the feasibility of random allocation.

6.6 Telephone Survey of Nurse Managers

Process Forty-seven nurse managers were identified as having previously nominated to the ENB 941 programme. Service-based teaching staff within Trusts were also identified via managers as a potential source of nominees. Only the Trusts subscribing to centre A were found to employ such staff. Figure 6.3 shows the number of managers nominating candidates to each of the centres and the number of service based educationalists across the programmes.

Figure 6.3 ***Number of nurse managers and service based educationalists nominating candidates to the ENB 941 per centre***

ENB 941 CENTRE	nominating managers	service-based educationalists
A1	13	9
A2	3	1
A3	7	3
B	10	0
C	6	0
D	8	0
TOTAL	47	13

Mindful of the need to liaise with all parties involved in the purchase and provision of programmes of education, the project team approached the Principal of each centre, the course leader and their head of department before making contact with the nurse managers.

Identifying the nominating manager was a protracted process, as was contacting each manager in order to conduct a telephone interview. On average three telephone calls were made per manager before reaching the interview stage with the interview taking place on the fourth call.

The telephone survey took place over eleven weeks. All forty seven nurse managers and thirteen service based educationalists were interviewed (n=60). Interviews lasted five minutes on average. Following a brief description of the study, respondents were asked to consider the possibility of random allocation of nominees. Educationalists were also asked to identify nurse managers who may be nominating to the ENB 941. This information helped to ensure that all nominating managers had been identified. Of note, only one nurse manager had not been identified by the project team.

Explaining the randomised controlled trial and matched sample to interviewees
Although the research design was fairly complex and difficult to convey over the telephone, most participants suggested that they understood the nature of a randomised controlled trial. However, subsequent correspondence suggested that in some instances this was not the case, since lists of nominees were accompanied with suggestions for which group they should be allocated to. Where the manager immediately raised objections to the notion of randomisation the interviewer introduced the matched sample design as an alternative. Following the telephone interview each participant received a letter reiterating the content of the interview and outlining the approaches to recruitment. They were then invited to identify nominees.

Factors influencing sample size and the feasibility of randomisation Whilst the majority of managers and educationalists were interested in participating in a study to evaluate the effectiveness of a programme which they purchased, they raised several issues which would influence the feasibility of randomisation. Responses have been categorised under the following headings:

- effect of health service reforms
- changes in the system of contracting resulting from Working Paper 10
- perceived effect on service provision
- lack of a standard process for nominating nurses to undertake programmes
- managers' perceptions of the relevance of the ENB 941 in the context of present service needs
- managers access to information about the ENB 941 from the School of Nursing

Effects of health service reforms Most managers suggested that even if they agreed to randomisation it was unlikely that the nominees would agree. Managers expressed the view that the health service was undergoing a period of rapid change in which the climate was very difficult and morale extremely low. Managers explained that some nominees had been waiting to undertake the ENB 941 programme for some time and may be reluctant, having secured a nominated place, to agree to the possibility of their place being deferred to a later programme. The minimum delay for nominees allocated randomly to the control group would be three months (Centre A), and the maximum delay seven months (Centre C).

Changes in the system of contracting resulting from Working Paper 10

There were suggestions that the establishment of education consortia and clinical directorates within Trusts had reduced managers' degree of control in relation to allocation of places on a programme. To agree to the research team randomly allocating nominees would reduce this control even further. Previously, managers had negotiated the number of post registration education places they wished to reserve for their staff directly with education providers. However, the devolution of education funds from Schools of Nursing to Health Service Trusts, meant managers now *purchased* places on courses. As a member of a directorate, managers could no longer operate independently in this activity. The manager now purchased places based on directorate funds allocated to education and continuing professional education had to compete with the directorate's other service needs. In two Trusts (Centre A and Centre B), educational budgets had been used to subsidise clinical directorate overspend (two directorates). Neither directorate was specifically designated 'health care for the elderly'. In both instances managers were unable to purchase places on the ENB 941 programme.

Several managers were waiting for a directive from the recently formed Regional Consortium. Managers were unable to give an indication of the approximate number of places they would be nominating to, until they had received information from the

Consortium. These factors reduced the number of nurses who were being nominated to the ENB 941 programme at the time of the study.

Perceived effect on service provision Over half of the managers expressed concern that randomisation would deplete the number of nurses in a clinical area if more than one nominee were allocated to the same programme. Staff were allocated to programmes on the basis of both service needs and training needs. Other factors influencing the release of nominees included annual leave patterns, sickness, maternity leave, ward cleaning, and ward closures.

Lack of a standard process for nominating nurses to undertake programmes The process for nominating nurses to undertake the 941 varied across the Trusts, directorates and between managers within a directorate. Some managers identified potential nominees through their performance review interview, others informed their staff of the programme through memorandum or flyer, whilst others waited for their staff to make their interest in the programme known to them. In some cases, places were only allocated shortly before the programme began.

Managers' perception of the relevance of the ENB 941 in the context of present service needs The ENB 941 programme was perceived by some managers as being too specific and by others as not specific enough. It was generally felt that the 941 did not meet the needs of the elderly mentally ill and those with dementia and that the programme emphasised the physiological changes of growing older. One directorate was developing its own programme to meet the needs of elderly mentally frail patients. Some managers suggested that the ENB 941 was too short to take account of the many and diverse needs of older people.

Some managers indicated that several or all of their staff held the 941 and/or 298 so there was no one to nominate. Several Trusts no longer had a designated care of the elderly unit or ward. The admissions policy was no longer age-related and older people were allocated to beds throughout the Trust. The 941 was felt to be less relevant by some managers within these Trusts.

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During the course of the telephone survey one hospital closed, another was due for closure by the beginning of 1996 and another was preparing to move to new premises. Each hospital had previously nominated staff to the 941. The manager of the latter hospital wished to remain at full complement of staff during the period of change, and therefore would not be nominating nurses to undertake the 941.

Managers access to information about the ENB 941 from the School of Nursing
Generally, managers felt that the centre provided insufficient information about the 941 programme to allow them to determine its appropriateness. Information booklets about the course were often incomplete or out of date. Changes in personnel, both administrative and teaching, made the acquisition of accurate and up-to-date information difficult. Contact between the manager and the course leader was often limited and information sometimes erroneous, for example one centre had provided managers with the wrong start dates for the programme. Some centres had moved into higher education and managers perceived that this move would reduce the number of ENB programmes offered by the centre, with increased emphasis on undergraduate and post-graduate programmes.

Additional points Several managers (Centre A) felt it was inappropriate to be evaluating the ENB Course 941 when it was undergoing considerable change: the course leader was leaving and being replaced by three course leaders, one per site. The curriculum had recently been reviewed, modularised and revalidated. Generally, managers valued the traditional non-modularised programme, where the nominee attended the centre for one week blocks over several weeks. The introduction of the new programme meant nominees were attending for two days per week over a period of several months. Managers explained that continuity of patient care was affected by this approach, as was the motivation of nominees. Nominees were reported to have little opportunity to develop a rapport across the group. Nominees were also said to have commented on the volume of written work in the form of research-based essays. The managers were unclear on the level of the ENB 941 programme following validation: two managers thought it might be at diploma level where previously it was certificate level.

Three managers (Centre D) were dissatisfied with the quality of the 941 and now nominated candidates to another programme. This centre was some distance from Centre D and meant nominees had to travel further.

Consequences By December 1995 the telephone interview survey was nearing completion and there was an indication of the sample size for both the matched sample and the randomised control trial. However, the estimated sample size was both approximate and tentative based on factors identified during the telephone survey. It was at this stage that the research team accepted the impossibility of generating a sufficiently large sample to conduct the randomised controlled trial and made a decision to pursue the matched sample option.

6.7 Summary of the Outcome of the Telephone Survey and Recommendations

Our original intention to conduct a randomised controlled trial to determine outcomes for the ENB Course 941 was dependent upon recruiting a sufficiently large sample of prospective course members who would agree to the possibility of having their admission to the programme deferred. The telephone survey suggested that this would be impossible within the time-frame of the study. Our attempts to generate the sample raised several methodological and logistical challenges which are likely to face other researchers attempting to use this approach to evaluate programmes of nurse education. These can be summarised as follows:

- difficulties in identifying and contacting nurse managers responsible for nominating to programmes of continuing professional education
- managers' and practitioners' difficulty in comprehending the nature of the RCT and what this might entail
- managers' perceptions of the effect of the RCT on service provision
- changes in the system of contracting for CPE reducing the number of places available

- lack of a standard process for nominating nurses to attend programmes
- practitioners reluctance to defer admission to an educational programme

Collectively these factors suggested that the RCT was inappropriate in the context of this study. The ever changing context of health care suggests that researchers will only ever be able to exercise 'limited' control over the events which they are studying. Certainly, researchers contemplating the use of an experimental design to determine the effects of educational programmes within nursing should ensure that projects are sufficiently resourced to allow:

- inclusion of a range of centres to increase the pool from which participants can be recruited;
- close liaison with nurse managers and course leaders to determine contractual arrangements and the process of nomination;
- time to familiarise nurse managers and practitioners with the nature of a randomised controlled trial and what this involves.

Chapter 7. Evaluation of the ENB 941 programme (Nursing Elderly People): methods

7.1 Overview

The evaluation of the ENB Course 941 consisted of three separate components:

1. a quasi-experimental questionnaire study (N=80) with one pre-course and one post-course measure

2. a quasi experimental observational study (N=30) with two pre-course and one post-course measure, complemented by qualitative field-notes

3. pre-and post course interviews with course members (n=20), their managers (n= 17) and course leaders (n=6)

7.2 Quasi-experimental questionnaire study The main intention of the questionnaire dimension of phase III was to determine the effects of a post-registration educational programmes on the knowledge, attitudes and practice of nurses working in a range of hospital and community practice settings. The questionnaire was designed to ascertain nurses perceptions of their practice in relation to older people and how they feel care should be provided.

Sample The sample of nurses for phase III was identified via a telephone survey of nurse managers in four centres (see chapter 6) and was a convenience sample. Nurse managers were asked to identify nurses they had nominated to undertake the ENB 941 programme and were then asked to identify a nurse who had not undertaken the programme matched on the following criteria:

- age
- gender
- qualifications
- work setting
- experience

Nurses identified by their nurse manager were contacted personally by telephone to negotiate their participation in the study. In some instances, it was not possible for the nurse manager to identify a matched person. In these cases, the nominated nurse was asked if he/she could identify a match. The final sample for the questionnaire study is indicated in Table 7.1.

Table 7.1 Participants in each centre invited to complete questionnaires

Centre	Nurses undertaking ENB 941 programme	Matched nurses
A	15	15
B	15	15
C	5	5
D	5	5
TOTAL	**40**	**40**

7.3 Quasi experimental observational study Fifteen well matched pairs in Centre A were selected for the observational element of the study. Two pre-course observations and one post-course observation were carried out with each pair (87 observations following attrition). Each period of observation lasted between three and a half and four hours. The observations for each pair were conducted on each occasion by the same observer and at the same time of day. The detailed protocol for observation is described in Section 7.5.

7.4 Instrumentation

7.4.1 Background The research team originally intended to make use of existing scales to measure attitudes and knowledge in relation to older people and to make minor adaptations to previously developed tools for observation. However, a deeper consideration of the theoretical assumptions underpinning the development and application of these tools suggested that their use would be inappropriate within the context of this study. In particular, commonly used scales such as the Kogan Old People Scale (Kogan 1961) and Palmore's Facts on Ageing Scale (Palmore 1977) have been developed to determine negative stereotypes and inaccurate knowledge about older people within the general population. The assumptions underpinning the use of such scales are based upon a linear model of the impact of education on nursing practice, that is that education influences attitudes to older people in society which influence nursing practice. We believe that such a model is too simplistic to represent the relationship between education and practice accurately and that multiple factors are in operation (Figure 7.1). A more useful focus within the context of this study would be to determine attitudes towards behaviour essential to the nursing care of older people. Wright for example identifies the need to reconceptualise attitudes to include concepts of individualised care, rehabilitation potential and choice (Wright 1988).

In considering existing tools for the observation of practice, it also became apparent that most of the available instruments focused upon broad quality of care indicators and were not sufficiently focused upon the promotion of autonomy and independence to meet the requirements of the study. The research therefore required the development of two instruments, a self-completion questionnaire and an observation schedule.

7.4.2 Self-completion questionnaire

The dimensions of interest relevant to the promotion of autonomy and independence identified within the literature review informed the development of items for the self-completion questionnaire (figure 7.2). Items were generated to reflect each dimension and then modified by the team as a whole. Wording was adjusted to ensure that each statement was as unambiguous as possible. A combination of question types was included to maintain respondent interest, including Likert scales, fixed-choice responses, multiple choice questions, ranking scales and a small number of open-ended questions.

Where appropriate, items from existing scales were incorporated into the questionnaire. A scale developed by Nolan and Grant (1994) was modified to reflect the dimensions of interest and incorporated as a whole. Selected items from a scale to measure patient centredness in nursing students (Rolfe 1993) were also incorporated.

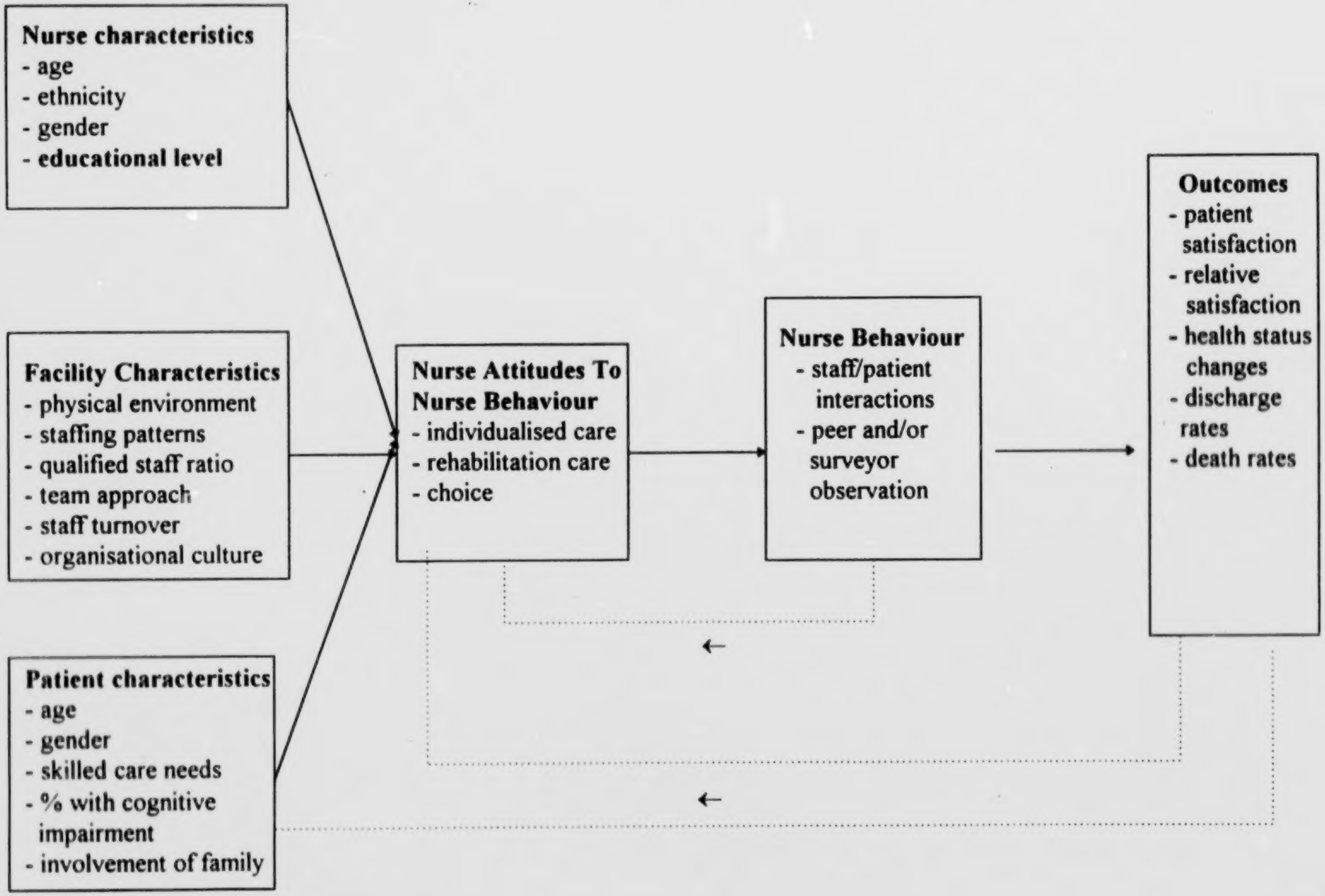
The questionnaire was designed in three sections. The first section sought information on demographic details, current educational level and issues relating to skills development in care for older people. The second section explored respondents' views on appropriate nursing practice with older people and what they actually do in practice. This section reflected the dimensions of independence, participation, information giving, communication and privacy. The third section explored these dimensions further but also invited the respondent to consider their practice in relation to the management of risk and to identify potential barriers to the promotion of autonomy and independence.

Pilot Study The questionnaire was piloted three times. The first two pilots were carried out with convenience samples of nurses undertaking post registration degrees and with nurses known to the project team. Respondents were asked to complete the questionnaire and give their views on the instrument on a separate sheet, including the amount of time taken for completion. Comments were also sought from members of the Steering Group. Adjustments to the wording, format and presentation of some items were then made and the questionnaire was piloted again with a sample of sixty nurses undertaking the ENB 941 programme in the four centres. Further adjustments were made and some items demonstrating little variability across the sample were excluded in order to reduce the length of the questionnaire.

7.4.3 Observation tool

Development of the observation tool was informed by the work of Gilloran et al (1994). An observation matrix was developed based upon dimensions of autonomy and independence identified within the literature. These were: choice; information/explanation; eliciting feedback; reciprocity; privacy; participation; independence (encouraging older people to do as much for themselves physically as possible) and safety. A four point rating scale was designed to enable each care event to be rated on each dimension of interest (Figure 7.3)

Figure 7.1 Relationship between education, nurse attitudes and quality of care


Nurse characteristics
- age
- ethnicity
- gender
- educational level
Facility Characteristics
- physical environment
- staffing patterns
- qualified staff ratio
- team approach
- staff turnover
- organisational culture
Patient characteristics
- age
- gender
- skilled care needs
- % with cognitive impairment
- involvement of family
Nurse Attitudes To Nurse Behaviour
- individualised care
- rehabilitation care
- choice
Nurse Behaviour
- staff/patient interactions
- peer and/or surveyor observation
Outcomes
- patient satisfaction
- relative satisfaction
- health status changes
- discharge rates
- death rates

Adapted from Wright, L. (1988)

Figure 7.2 Dimensions and indicators for the concept autonomy

Concept	Concept Specification (dimensions)	Indicators (examples of questionnaire items)
Promoting autonomy for the older person	Choice	Patients and clients should be allowed to choose ways of behaving/types of care that are not necessarily in line with the views of the health care team
	Information	I ensure that patients/clients attend all meetings at which they are discussed
	Consent	Before talking to a relative about a patient I always ask the patient's permission
	Eliciting feedback	I generally ask a person what they understand and how they feel before commencing a procedure
	Participation	Patients'/clients' views are taken into account in decision making
	Individualised care	A full assessment is made of patients prior to giving care
	Taking risks	It is appropriate to take risks with the patient's safety in the interests of promoting their autonomy
	Recognising personhood	Talking to patients as individuals is an important priority of care

Figure 7.3 Rating codes for observation schedule

Rating codes:

0- not at all
1- infrequently/misses most
opportunities
2- intermittently/takes some opportunities
3- consistently/takes most-every
opportunity

Initially, a narrow range of nursing interventions was identified to act as the focus of observation, in order to allow the development of precise criteria for scoring each dimension of interest. The activities were:

- evaluating and planning care
- helping a patient to wash/bathe
- administering prescribed drugs
- helping a patient to mobilise or change position
- technical procedures

It was intended that these discrete nursing activities would provide the vehicle through which the observer could assess features of the interaction between the nurse and patient/client, according to the dimensions of interest covered within the self-completion questionnaire. However, early pilot work suggested that none of these activities occurred with sufficient regularity in all of the practice settings to provide sufficient data within the time available for direct observation of practice. Focusing on these activities alone would have resulted in observers spending lengthy periods of time in effect 'waiting for something to happen'. The research team then experimented with the possibility of attempting to score all nursing activities which involved direct patient contact and were of sufficient duration to allow judgements to be made. The tool was piloted in a range of care settings, including acute hospital wards, rehabilitation wards, in-patient facilities for the elderly mentally ill and in the community. The observers found it was possible both to score individual activities continuously and to record features of each event which had contributed to their scoring an activity in a particular way

Through the maintenance of continuous field-notes alongside each observation, the three observers were able to develop a set of criteria for scoring activities on each of the dimensions of interest. Observation of video material featuring nurses interacting with older people allowed further refinement of these criteria (Appendix VIII)

The views of a small convenience sample of older people with recent experience of receiving nursing care were sought through a small number of semi-structured interviews. Issues arising within these interviews allowed us to consider the appropriateness of the instrumentation from a service-user perspective. The interview process and themes arising from the interviews are included in Appendix VI.

7.5 Procedure for observation

A protocol was developed to standardise the approach to each observation. On the first visit to an area, the observer spent approximately one hour familiarising herself with the practice environment and with patient/client needs. During this period, verbal permission to observe was negotiated with staff and patients/clients. Although the observation focused on the practice of one nurse, activities of other staff and patients were also recorded in field notes and it was important that this was negotiated. Information sheets about the study were available for staff and patients.

Information about the setting, including the number and type of patients/clients, number and grade of staff on duty, layout of the environment, and approach to organising care was recorded on a front sheet to the observation schedule (Appendix VIII). Once the participant and observer felt comfortable, detailed recording of observations began. Each care event was observed in it's entirety and the observer maintained written field notes throughout. At the end of each event, the rating scale was completed. The activity was coded and the complete event or part of event was rated on the four point scale for each dimension of interest. For example in relation to helping a patient to wash, the observer would record 3 in the box for choice if she felt that the patient was offered choice appropriately about the timing of the wash, type of wash and place of care. Some dimensions of interest were recorded as not applicable for some care activities.

The time at which each event started and finished was recorded as well as the number of nurses involved. The observer then 'keyed in' to next event. Each observation period continued for a minimum of three hours. At the end of each period, brief information about the older people in each care event was recorded, including gender, age, reason for care and cognitive ability.

Examples of the rating for selected events together with field-notes are included in Fig. 6.4 to provide further illustration of the observation process.

Interviews Semi-structured interviews were carried out with a sub-sample of the respondents to the questionnaire study (n = 20), their managers (n = 17) and course leaders (n = 6). A sample of convenience of those respondents who had indicated on their consent form that they would be willing to participate in an interview were contacted and a mutually convenient time arranged. Managers and course leaders were contacted by telephone and invited to participate in this aspect of the evaluation. All who were contacted agreed to take part.

Differently worded schedules were used for each of the three groups of participants although similar issues were covered in each (Appendix X). Interviews lasted between twenty-five and seventy minutes and were tape-recorded.

Ethical issues Ethical approval was sought from the local research ethics committees associated with each educational centre providing the ENB 941 programme (n = 22). Only one educational centre had a formal ethics committee from which to seek approval. All LRECs eventually approved the study although there was enormous variability in the extent to which they considered the study design. At one extreme, several committees suggested that the study represented audit rather than research, and therefore did not require ethical approval. At the other extreme, several committees required completion of a detailed proforma and one committee requested a verbal presentation of the study.

Once a potential recruit to the study was identified, s/he was contacted by telephone and the nature of the study was explained. Written information was then posted to each nurse, including a written consent form for the participant to sign and return. The information sent to participants stressed that the research team would respect the confidentiality of all information collected within the study.

The observational element of the study raised important questions in relation to privacy and confidentiality, although interestingly, none of the Local Research Ethics Committees raised this as an issue. Observers introduced themselves to older people within each care setting and sought verbal permission to observe events where appropriate. Other staff in each area were informed verbally and given information sheets about the project. The research team felt it important to maintain a balance between collecting accurate data and respecting the privacy and dignity of older people receiving nursing care. In practice, the three observers - all qualified nurses, relied on their own professional judgement to determine when it was inappropriate to observe a particular care event. Observers intervened directly in care-giving only when they judged a situation to be potentially dangerous.

7.8 Data Analysis

Responses to the questionnaire data and the observational ratings were pre-coded for computation and analysed using SPSS(win) version 6.0 (Microsoft 1993). Differences between proportions to the questionnaire responses were assessed using the chi square statistic. Differences in mean ratings for the observational data were assessed using the Mann Whitney U Test.

Responses to the open-ended questions on the questionnaire were entered onto a database and content-analysed for themes.

Procedures for analysing the observational data are discussed in Chapter 8.

Interviews were transcribed in full onto a data matrix. The matrix included a number of columns and each entry was annotated under the following headings: facts, codes and theoretical notes. The matrices were then analysed for recurring themes in relation to changes in knowledge, attitudes and practice/intention to practice.

Fig. 7.4 Examples of event ratings and field-notes

Activity codes:
1- Communicating
2- Eliminating
3- Eating
4- Drinking
5- Personal hygiene/grooming
6- Dressing
7- Mobilising
8- Providing recreation
9- Technical care (identify in fieldnote)

Rating codes:
0- not at all
1- infrequently/misses most opportunities
2- intermittently/takes some opportunities
3- consistently/takes most/every opportunity

Example 1 Setting: acute medical ward

ACTIVITY: 9	choice	information/ explanation	eliciting feedback	reciprocity	privacy	participation	independence	safety	1 full 2 part	No. of carers
EVENT NO: 12	1	1	2	2	n/a	0	0	3	1	1

Patient No F 72 (2) Time started event: 08.30 Time finished event: 08.35

Drug administration
N Mary Hello....are you going to have your tablet for me?
Have a drink...have a drink now Mary
Put cup to lips then placed tablets in mouth
N You're smiling a lot this morning - you're full of smiles aren't you
Put cup to lips
Used syringe to put medicine in mouth
Stayed for about a minute kneeling by patient, smiling and holding her hand, asking if she was OK

Choice: Directing language, limited choice - coded 1
Information: No information about medication but some commentary on actions - coded 1
Eliciting feedback: Asked if patient was OK and took time but could have asked more specifically how she was feeling - coded 2
Reciprocity: Physical contact, took time, smiling - coded 2
Privacy: patient in side room, not an intimate procedure - coded n/a
Participation: no info re drugs or attempt to plan for the day (first contact of day) - coded 0
Independence: no attempt to encourage patient to take drink or tablets - coded 0
Safety: checked wrist label, checked drug chart - coded 3

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Example 2 Setting: rehabilitation ward

ACTIVITY 5	choice	information/ explanation	eliciting feedback	reciprocity	privacy	participation	independence	safety	1 full 2 part	No. of carers
EVENT NO: 12	1	1	1	0	0	0	1	3	2	1

Patient No M 69 (1) Time started event 09.12 Time finished event: 09.14

N Are you going to have a shower?
P Yes (P had previously asked for a bath)
N You're soaked.
P Yes I was shouting you
N helped him onto the shower chair. Did not draw curtains. Wheeled to shower (in wet pyjamas).
N You hang on to your bowl. I'll just see how John's managing
Stopped to check on another patient, left P in the middle of the bay, sitting on the shower chair holding his washing things.

Choice: Did not respond to patient's previous request, offered shower in directing manner - coded 1
Information: some commentary on nurses' actions but left without giving an indication of how long she would be - coded 1
Feedback: Use of OK? - Coded 1
Reciprocity: seemed rushed. No attempt at social conversation. Accusatory -'you're soaked' - coded 0
Privacy - exchange took place in open bay in full view of other patients - coded 0
Participation: No attempt to ascertain why patient may have been incontinent - coded 0
Safety: Safe transfer. Put brakes on wheelchair - coded 3

Example 3 Setting: Community

ACTIVITY 1	choice	information/ explanation	eliciting feedback	reciprocity	privacy	participation	independence	safety	1 full 2 part	No. of carers
EVENT NO: 12	3	3	3	3	n/a	3	n/a	n/a	1	1

Patient No F 71 (1) Time started event 12.29 Time finished event: 12.40

Assessing patient's needs following a fall and hand injury. P just finishing lunch. N offered to call back later
N You must have got a terrible shock
Encouraged P to finish lunch
Read letter from hospital to P
N Is it giving you a lot of pain? N kneeling in front of P P asks if OK on floor
N - You get two little pads on your knees as a district nurse

Choice: asked permission to read letter. Offered to call back - coded 3
Information: read letter to patient. Explained why she was there - coded 3
Feedback: Continually attempted to elicit the patient's perspective on what had happened - coded 3
Reciprocity: comfortable physical contact, offered information about herself - coded 3
Privacy: patient's own home, non-intimate procedure: coded n/a
Participation: Provided basis for patient to give views on plan of care - coded 3
Independence: no physical activities involved - coded n/a
Safety: coded n/a

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Chapter 8. Evaluation of the ENB Course 941 (Nursing Elderly People): findings

8.1 Introduction

Findings of the detailed evaluation of the ENB Course 941 (Nursing Elderly People) are presented as follow:

- questionnaire analysis
- analysis of structured observational ratings of nursing practice
- themes and issues emerging from observational field-notes
- analysis of interview data

8.2 Analysis of questionnaire data

Analysis of the pre course questionnaire was undertaken in order to achieve a base line picture of respondents in relation to the areas of interest of the study.

8.2.1 Response rate

The recruitment process identified a total of 80 nurses who agreed to participate in the study. Following one postal and one telephone reminder, 61 nurses had returned the pre-course questionnaire, a response rate of 76.3%. These 61 nurses were sent a second copy of the questionnaire after the programmes had completed. Unfortunately, responses were received from only 38 nurses, in spite of one postal and one telephone reminder. Complete data sets (that is one pre-course and one post-course questionnaire were therefore only available for 38 respondents, 19 course members and 17 matched controls. This disappointing response rate has limited interpretation of the pre- and post-course data. However, the baseline questionnaires provide useful insights into the attitudes and current practice of a convenience sample of nurses working in a range of care settings and these findings are reported, together with trends apparent within the quasi-experimental data.

8.2.2 Characteristics of respondents

The age range of the total number of respondents (n = 61) was 22 to 56 years. Years of experience ranged from three months to 28 years with most nurses having less than five years experience (31% n = 19). The majority of respondents were female 85% (n = 51). Most respondents described their job title as staff nurse (57% n = 33) and the sample included a spread of grades from 'C' to 'G', with D the most frequently occurring grade (45.9% n = 28).

In relation to nursing qualifications:

- Most respondents had trained before the Diploma in Higher Education pre-registration programmes were introduced (58% n = 35).
- 43% (n = 25) of respondents held the enrolled nurse qualification
- 18.0% (n = 11) had a registered mental health nurse qualification.

Other qualifications included ENB courses, conversion and other registered nurse qualifications (e.g. district nursing certificates and midwifery), diplomas, National Vocational Qualifications (NVQs), management courses and nursing practice courses).

Table 8.1 shows the number of nurses working in each area for the nominee and matched groups.

Table 8.1 Work setting for respondents, nominee and matched groups

AREA OF WORK	NOMINEE	MATCH
Elderly specific: acute	1	1
Elderly specific: rehabilitation	16	8
Elderly specific: continuing care	7	3
Elderly mental health: acute	1	1
Elderly mental health: continuing care	3	0
Non specific	8	9
Community	2	1
Total	38	23

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The non specific areas of work are those that take patients of all ages for example opthalmics, orthopaedics, accident and emergency. Community settings include district nursing and community psychiatric nursing.

Most nurses (85% n = 52) provide care for patients of both genders within their work area. When asked if they had chosen to work with older people 66.7% (n = 22) of nominees and 53.6% (n = 15) of matches said they had chosen to work with older people. Comments suggested that some nurses worked with the full range of ages not just older people and that working in the area of care of the elderly enabled more flexibility of work pattern for those with children.

8.2.3 Educational needs and skills development Respondents were invited to assess their knowledge in the area of caring for older people and to consider the skills that they used in their present area of work. When asked how well their training and education had prepared them to care for older people, the majority felt they were prepared to some extent (70% n=43). Most respondents (75% n = 46) felt that post basic training was desirable for nurses to care effectively for older people.

We invited respondents to list areas in which they felt that their knowledge or skills needed to be improved in order to care effectively for older people. There were 75 different responses and a thematic format for organising the responses was used.
The most popular theme was linked to physical aspects of care. The responses in this theme were wide ranging, for example understanding drugs and drug interaction in the elderly, physiology of ageing, hearing aid maintenance and recognition of the multiple problems that care of the older person presents:

> *..many elderly patients have numerous problems when in hospital so one treatment may conflict with another observing for so many things happening is quite a skill.* (acute medicine)

Many respondents wanted to develop their knowledge in the area of psychology and mental health, for example care of older patients with mental illness, sexuality and the older person and knowledge of dementias. Some comments suggested that respondents were seeking to develop a more holistic approach to nursing older people by developing several aspects of their care and knowledge.

> *Increase understanding of the effects of ageing i.e. physical, psychological, social.* (acute medicine, surgery)
> *An understanding of an elderly person living in the community.* (rehabilitation)
>
> *More awareness/experience of fit/active elderly population.* (acute elderly medicine)

Other responses suggested the need to develop communication skills including counselling skills, general educational needs, managerial aspects and ethical knowledge. Some of the developmental needs identified particularly reflected the dimensions of interest within the study.

> *Made aware of more research based knowledge/skills.* (accident and emergency, acute elderly psychiatry, rehabilitation)
>
> *Encourage the contribution/participation of the older person and their carers in nursing decisions, decision making.* (psychiatric continuing care)
>
> *To be able to demonstrate a commitment to anti ageist practice through the care which is given to the older person.* (psychiatric continuing care)
>
> *Training in how to go about implementing new practices especially how to overcome staff resistance to change.* (rehabilitation)

The post course questionnaire responses repeated these themes and no new categories were identified. The theme of educational needs was more prominent in the post course responses for course members, suggesting that the course may have raised participants' awareness of their need for continuing education.

> *More training with physio and OT staff to be fully aware of their work.* (rehabilitation, continuing care)
>
> *Teaching and training skills to help other members of staff care for older people.* (rehabilitation)
>
> *Knowledge of risk assessment.* (elderly psychiatric care)

Table 8.2 indicates how respondents felt their skills were used at baseline. There were no differences between the two groups. In responding to the post course questionnaire, more of the course attendees indicated that they felt that they made good use of their technical skills. This may suggest that the programme raised nurses' awareness of the skills that they use.

Table 8.2 Skills utilisation in current post (baseline)

SKILL	UTILISATION IN CURRENT POST					
	very little use %	little use %	some use %	good use %	very good use %	TOTAL n
rehabilitation	3.4	11.9	28.8	32.2	23.7	59
technical nursing	8.8	14.0	38.6	28.1	10.5	57
management	3.4	5.1	33.9	39.0	18.6	59
teaching	5.1	13.6	50.8	25.4	5.1	59
communication	0	0	15.3	37.3	47.5	59
research application	15.3	23.7	44.1	11.9	5.1	59

Table 8.3 shows how nurses feel their time is spent during a normal working day (pre-course assessment). The questionnaire invited respondents to rank a series of activities, with 1 being the activity which they felt took up most of their time and 6 being the least. The activity rated 1st or 2nd by most respondents was completing paperwork and documentation. Stimulating patients to take an interest in themselves and their surroundings was rated 1st or 2nd by the least number of respondents.

8.2.4 Attitudes and practices in relation to the promotion of autonomy and independence

Nursing Organisation and Practice Participants were asked to indicate the desirability and feasibility of a series of approaches to the organisation of patient care. These related to the role of assessment in care planning, involving patients in care planning, priorities in care giving and models as a basis for organising care (Question 15).

Table 8.3 Respondents assessment of time taken in a range of activities

ACTIVITY	RANK (TIME TAKEN)			
	1 %	2 %	6 %	TOTAL n
Helping patients /clients to move around and become more mobile	10.2	15.3	11.9	59
Encouraging patient /clients to do things for themselves	22.0	22.0	3.4	59
Keeping patients clean and comfortable	22.0	23.7	13.6	59
Communicating with patients/clients	28.8	13.6	1.7	59
Completing paperwork /documentation	27.1	22.0	6.8	59
Stimulating patients to take an interest in their surroundings and themselves	6.8	6.8	55.9	59

There was agreement that most of the statements were desirable and either always or sometimes possible. Some respondents indicated that they did not agree with the use of nursing models and some suggested the use of named nursing or team nursing as the preferred method of organising care rather than primary nursing. Analysis of the pre- and post-course responses showed an increase in the number of respondents finding the approaches desirable and possible. For the statement regarding health promotion forming an important goal of care , the difference between the two groups was statistically significant (p = 0.017) when comparing the nominee and matched groups.

Choice A series of questions asked respondents to indicate the degree to which they gave older people choice in relation to day-to-day activities within their normal practice. Although there were no statistically significant differences between the groups pre- and post-course, some of the comments provide insight into the barriers to promoting personal autonomy. For example in response to a question asking whether they offer patients/clients a choice over the time during the day when they have a wash / bath/shower, respondents commented:

> *Can't always fulfil patients request for this activity due to staff numbers but would negotiate with client and come to some agreeable arrangements.*
> (rehabilitation)

> *Bath time tends to be fixed to evening usually to busy early morning to offer baths. (rehabilitation)*

> *Our patients tend to have a strip wash before getting dressed and are offered washing facilities prior to going to bed.* (rehabilitation)

> *Has to depend on staffing levels and dependency of in patients at any given time.* (acute medicine, surgery, rehabilitation)

When asked whether they allow patients /clients to determine when their own clothes are changed, most comments related to problems arising from cognitive impairment:

> *Occasionally some clients refuse to change soiled clothes due to disorientation. On these occasions they are actively encouraged to change.*
> (elderly psychiatry)

> *Sometimes - never. Most of my patients severe end stages dementia. Nurses see to these needs and keep patients clothes clean.*
> (psychiatric continuing care)

> *When a patients clothing is soiled I suggest a clean article is required but if the patient insists on wearing the item I honour their decision. Relatives need to be informed of this.* (rehabilitation)

Some questions related to seeking an older person's consent to nursing actions, for example: *Before you talk to a relative about a patient do you ask the patients permission?* The most frequent response to this question was 'sometimes' and the comments were particularly interesting. Some nurses answered very honestly by admitting that they had not thought about asking the patient.

> *Something I have never thought about with being a continuing care ward.*
> (continuing care)

> *This would depend on the clients mental condition. To be honest I have not always given this thought.* (rehabilitation)

Others did ask the patients permission.

> *On admission we ask patients permission to talk discuss condition with close family. They will indicate who they do or don't wish for us to discuss things with. But maybe not on a daily basis.* (acute medicine)

> *Patients have in the past requested relatives not to be informed of certain things. If I feel questions asked by relatives are compromising I will ask them to talk to the patient or involve them in the conversation.* (rehabilitation)

A subsequent question asked respondents whether they encourage patients/clients to plan for the future. Again the most frequent response was 'sometimes' and there were no differences post course. Most nurses who commented (n=27) were keen to enable older people to participate in future planning.

> *I try always to talk of the future as I feel it helps to keep patients motivated but try to be realistic in this as the future may not always be so hopeful.* (rehabilitation)

> *Family members and carers are included in discharge planning.* (rehabilitation)

In order to explore the potential value of 'therapeutic reciprocity' as a strategy for promoting autonomy, respondents were asked whether they share aspects of their life with patients and clients during conversation. The most frequent response was 'often'. Some nurses commented on the types of information that they share with patients and others identified the therapeutic value of this type of communication.

> *You can find out a lot about your client and fulfil their need at the same time. It can uplift and gets them to talk.* (rehabilitation)

> *To share information and build therapeutic relationship.* (psychiatric continuing care)

> *It allows the client to see you as a person too! Sharing feelings and experiences outside the role of nursing.* (rehabilitation)

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The questionnaire also asked respondents whether they let older people know when working with them made them feel good. The most frequent response was 'often' and there were no differences post course. Fourteen nurses added comments, for example:

> *When patients comment that I'm being kind, helpful etc. I tell them I appreciate it.* (rehabilitation)

And again one respondent commented that she had not thought about this.

> *Again it is something I have never thought about. It would probably raise patients' moral* (sic) *if I did.* (psychiatric continuing care)

Most respondents identified specific areas in which they offered health education and promotion to older people. These included general dietary advise, self medication, effects of drugs, smoking, hygiene and more specific care such as for those patients with catheters or who had conditions such as diabetes. When asked whether they encourage elderly patients /clients to evaluate their progress, the most frequent response was 'sometimes' and again this was not significantly different post course. Respondents who commented (n = 15) felt that to encourage patients to evaluate their own progress was important and valuable.

> *I always ask how they feel they are managing with daily routines and aims and objectives.* (continuing care)

However some also showed that evaluation was nurse led rather than patient driven.

> *I always try to emphasise progress made to encourage patients.* (rehabilitation)

Privacy Respondents were invited to suggest as many ways as possible for safeguarding a patient's privacy within their own practice setting. Ninety four separate strategies were identified covering four main themes These mostly related to physical caring and activities of daily living.

> *Always ensure use of curtains for privacy.* (all areas, suggested by n=33)

Knock before ask permission before entering toilet, bathroom, bed area etc.
(all areas, suggested by n=6)

Encouraging patient to use the bathroom instead of washing behind the curtains at the bedside. (rehabilitation, acute medicine)

Another key theme was confidentiality of information.

Discussing problems etc. in private. (all areas suggested by n=16)

Lowered tone of voice when asking questions in a communal setting.
(psychiatric elderly care)

Not giving info out without patients / OK permission.
(psychiatric elderly care, acute medicine)

Other themes related to personal space, and choice.

Time needed to be with spouse. (rehabilitation)

Allowing them to discuss fears and anxieties without interruptions.
(rehabilitation)

Give them choice 'do you mind if?' (accident and emergency)

The post course questionnaire responses did not reveal any new ideas in relation to promoting patient and client privacy.

Participation Respondents were asked to indicate the extent to which they agreed or disagreed a series of statements reflecting views on patient/client participation in planning care. Responses are reported in full in Appendix IX. These questions prompted a spread of responses at baseline. There were no statistically significant differences between the two groups post-course, but a trend towards responses reflecting more positive attitudes by the group of course attendees.

In addition to exploring attitudes to patient participation, the questionnaire attempted to describe current practice in relation to this dimension. Details are included in Appendix IX. In interpreting these responses it is important to recognise that nurses may not be able to exercise control over some aspects of decision making. For example, one item asked respondents whether they try to ensure that the nurse who knows the patient/client best is present for major procedures or to give detailed information to the patient. Comments highlighted difficulties in relation to shift patterns and off duty. Some respondents replied that they had not thought of this before.

If possible a very good idea. (continuing care)
Something never thought of on my behalf. (psychiatric continuing care)

Promoting autonomy and independence in nursing practice

The team asked participants how they felt autonomy and independence could be best promoted in their area of work. Seven themes emerged:

- individualised care - *discussing care plans*
- respecting an individuals wishes
- information giving - *ensuring informed consent at all times*
- participation - *helping and encouraging patients to make and plan their activity programmes once they are well enough, having a patient/client committee*
- promotion of independence - *as soon as able to encourage to attend to own hygiene needs, multidisciplinary team approach to care*
- the importance of the nurse/patient relationship - *to listen to their problems*
- education of all staff in this area - *education of all people who come into contact with clients during their working day to highlight the importance of a joint partnership between the clients and the giver of care.*

It is of note that these themes largely reflect the dimensions of interest identified from the literature review within this study.

Barriers to the promotion of autonomy and independence were:

- lack of time and/or staff.
- patient/clients condition including both physical and mental health
- the attitudes of staff members
- environment and resources

- patient expectations
- patients lack of motivation

The dilemma of balancing safety/risk with a persons autonomy and independence was identified by one participant :

> *Risk taking -some clients behave in a way that is dangerous to themselves or sometimes others. Safety is an issue.* (elderly psychiatric care)

These themes remained prominent in the replies to the post course questionnaire. One participant interestingly noted that

> *...policy focusing on the responsibility of the nurse is the major hindrance.*
> (elderly psychiatric care)

When invited to think of situations where promoting autonomy and independence conflicts with safety, the most common example given was that of problems with patients/clients wanting to mobilise when they were unsteady or prone to falls. Mental health problems also featured strongly:.

> *A patient who had falls wanted to continue to walk to and from the toilet which she had every right to do but staff felt she was unsafe and wanted her to ring her bell when she wanted to go so we could walk either but she insisted on doing it herself in fact the patient did have a nasty fall.*
> (rehabilitation)

> *A patient who needed to be locked into her own home with an open fire to prevent theft or possible assault on her person. She was strongly opposed to residential care although exhibiting little self care.* '
> (community)

In order to determine how nurses decide when they will override an older person's right to self-determination, the questionnaire asked participants to list any criteria that they would use to decide that the risk to safety outweighs a patient's rights to make their own decisions. Most responses suggested that nurses would take into consideration whether the patient/client were a danger to themselves or to others and their condition, both physical and mental. Only twelve responses showed any clear evidence of assessment before a decision was made.

First listen. Then validate and assess e.g. confusional state. (continuing care)

Suggestion and discussion. (rehabilitation)

Table 8.4 indicates the extent to which respondents suggested they used different forms of restraint.

The responses post course showed no significant differences but did show a trend to using dissuasion as opposed to the other methods for reducing risk.

Table 8.4 Respondents use of different forms of restraint.

APPROACH	FREQUENCY OF USE				
	yes in most circumstances %	yes in some circumstances %	hardly ever %	never %	TOTAL n
cot-sides / bed rails	3.3	73.8	13.1	3.3	**61**
arranging furniture to impede movement	3.3	18.0	29.5	49.2	**61**
use of sedative drugs	0.0	31.1	36.1	32.8	**61**
verbal commands	19.7	50.8	18.0	11.5	**61**
dissuasion	50.0	46.7	1.7	1.7	**61**

The questionnaire asked what the participants would say to a patient/client in three different situations. The first of these was:

- ***when patient/client insists on walking unaided but you know they are likely to fall, what do you say to them?***

Seventy two responses were collapsed into six different themes. Fifteen responses suggested evidence of negotiation or discussion with the client/patient:

> *Try to give patient enough information as to why they should have aid.*
> (surgery)
>
> *Find out what patient would find acceptable to aid walking i.e. holding onto furniture, door knobs, etc. or walking with them to get help if necessary take a chair etc.* (community)
>
> *I understand that you are eager to become independent again but I am concerned that you are not quite ready to go it alone yet. Do you not think it would be wise at this stage to use the aid provided for you?*
> (rehabilitation)

Many of the responses suggested that the nurse should offer an explanation and assistance to help the patient/client.

> *Ask if you can assist them in any way.* (elderly psychiatric care)
>
> *I can't stop you from trying to walk on your own but I think you'll harm yourself if you do. Let me help you now and you can practice and gain confidence.* (acute elderly psychiatry)

In some cases this was achieved in a negative controlling way.

> *Try to reason with them. If they still wish to walk unaided then I would say well I have explained why you require aid. I have to document in your notes and if you fall I can't be held responsible.* (acute medicine)
>
> *Please sit down if you insist on walking without help you are likely to fall and seriously hurt yourself.* (acute medicine)

The themes identified were consistent with the responses for the post course questionnaires although the negative explanations apparent in the pre course responses were less apparent among the post-course responses for course attendees One participant suggested a forward thinking approach that could be used with some patient/clients:

> *Ask them to help you remove dangerous objects from the area and if possible have fall practice involving crawling on floor and using furniture to attain a comfortable position. Discuss ways of seeking help after a fall.*
> (community)

The second question in this series asked:

- ***When an older person refuses help or even to use a napkin/bib when eating, what do you say to them?***

Most nurses responded that they would respect the patients' wishes and offer assistance if required to gain sufficient nutritional intake. However some appeared to fail to recognise the possibility of negotiation in their responses:

> *They will appear untidy and cause upset for themselves because I should have to change their clothes.* (surgery)
>
> *Tell them that you will help with hand washing after lunch* (surgery)
>
> *Explain the food may become cold and their clothes may become soiled.* (accident and emergency)

There was no difference in themes in the post course responses.

The third question in this series asked:

- ***When a confused patient/client wanders and attempts to leave the ward/home, what do you say?***

Most of the participants suggested that they would use diversionary tactics or communication skills to persuade the patient to stay on the ward; some however would also offer supervision and try and talk through with the individual reasons for their wishing to leave:

> *Talk with them find out why they wish to leave - maybe there is something you can solve on the ward.* (acute elderly psychiatry)
>
> *Take client to a quiet corner sitting her/him down talk to her/him to find out why he/she wants to leave and respond appropriately. For example concern about pet - contact clients relative or social worker to ensure pet is safe.* (acute elderly psychiatry)
>
> *Sit and talk with them until they feel safer.* (rehabilitation)

Finally, respondents were asked their views on a series of statements concerning the relationship between personhood, autonomy and safety (Table 8.5). Responses are presented for the sample as a whole at baseline There were no significant differences between the nominees and matched groups pre or post course. It is difficult to interpret these responses given the range of practice settings in which respondents were working However, there does appear to be an emphasis on safety considerations and the need to minimise risk for many respondents.

Table 8.5 Respondents view of statements about the relationship between personhood, autonomy and safety

STATEMENT	agree %	total (n)
safety and medical care considerations overwhelmingly dominate	29.5	61
the promotion of the patients autonomy has to come second	14.8	61
the promotion of the patients autonomy can be pursued at quiet times of the day	29.5	61
it is always possible to respect a patients individuality and personhood even when countermanding their wishes for clinical reasons	63.9	61
it is appropriate to take risks with the patients safety in the interests of promoting patient autonomy	24.6	61

8.3 Observational study

8.3.1 Sample Two pre-course observations were carried out with fifteen matched pairs (thirty nurses in total). One nurse withdrew from the ENB Course 941 following the introductory day and two course members were forced to withdraw at a later stage due to illness. Complete observational data-sets consisting of two pre-course and one post-course observation were therefore available for twelve matched pairs. The distribution of types of practice environment for this sample are presented in Table 8.6

Table 8.6 Number of pairs observed within each practice environment

PRACTICE ENVIRONMENT	PAIRS
Acute medicine	4
Rehabilitation	2
Elderly mentally ill (acute)	2
Opthalmic	1
Community (district nursing)	1
Accident and emergency	1
Orthopaedics	1
TOTAL	**12**

As intended, a range of practice environments were represented within the sample, although there were no nurses working in settings providing predominantly continuing care. The number of events rated for each group at each observation are shown in (Table 8.7).

8.3.2 Description of events In order to identify the range and frequency of activities upon which the ratings were based, the frequency with which each activity was observed was calculated for each type of setting (Table 8.8).

Table 8.7 Number of events for each observation by group

OBSERVATION	GROUP		TOTAL
	Exp.	Cont.	
1	154	184	338
2	195	205	400
3	197	198	395
TOTAL	**546**	**587**	**1133**

Table 8.8 Frequency of rated activity for each setting

ACTIVITY	SETTING						
	Medicine	Community	Rehab.	EMI	Surgical	A&E	TOTAL
Communication	24.7	32.4	17.5	24.6	9.6	79.6	**261**
Elimination	10.4	1.4	4.7	1.7	8.3	0.0	**67**
Eating	0.1	0.0	8.0	3.4	2.6	0.0	**36**
Drinking	0.2	0.0	2.2	0.5	2.6	0.0	**17**
Personal hygiene/ grooming	16.7	0.0	21.1	16.2	20.4	0.0	**168**
Dressing	1.7	0.0	6.5	4.5	4.5	0.0	**39**
Mobilising	9.0	1.4	17.8	8.4	14.6	0.0	**120**
Recreation	0.0	0.0	0.0	0.0	0.6	0.0	**1**
Technical care	37.8	64.8	22.2	40.8	36.9	20.4	**384**
TOTAL EVENTS	**357**	**71**	**275**	**179**	**157**	**54**	**1057**

The most frequently observed activities in all settings with the exception of A&E, related to technical care, most commonly drug administration, wound dressings and clinical observations (temperature, pulse, blood pressure). Within A&E, communication, in particular relating to assessment was the most frequently observed activity. Communication not directly related to physical care-giving and activities relating to personal hygiene and grooming formed a large part of the nurses' activity within most settings.

The time taken for each activity ranged from one to sixteen minutes (mode 1 minute, median 3 minutes). There were no differences between the experimental and control groups in relation to the time taken for events.

8.3.3 Ratings for each dimension of interest

The ratings from the pre-course observational periods for both the experimental and control groups were analysed collectively to indicate the spread of ratings across the values of the scale. The frequency with which each rating was recorded for each dimension is presented in Table 8.9 (N.B. this table includes all baseline rating for all thirty nurses).

Table 8.9 Frequency of ratings for all events recorded during baseline observations

RATING	DIMENSION							
	choice %	giving information %	eliciting feedback %	reciprocity %	privacy %	participation %	promoting independence %	safety %
0	44.4	13.4	26.8	47.5	28.2	45.7	27.2	8.5
1	14.1	33.8	26.0	21.3	15.5	26.1	20.6	8.1
2	19.7	24.7	18.3	15.7	16.8	16.1	15.9	8.5
3	21.8	28.1	28.9	15.5	39.6	12.2	36.4	74.8
n (events)	**958**	**1016**	**1033**	**981**	**710**	**740**	**869**	**822**

The differences in the number of events analysed for each dimension reflect the decisions of the observers as to whether it was appropriate to attempt to rate a particular dimension for a particular event.

The data appears to suggest that nurses within the study at base-line were particularly likely to miss opportunities to offer choice to those in their care and to encourage older people to participate in decisions about their care. However, the collective figures conceal wide variations between individual nurses in the study. For example the mean ratings for the dimension 'offering choice' ranged from 0.00 to 3.00. On the other hand the nurses in the study appeared to be acutely aware of safety measures and there was evidence to suggest that actions to promote patient safety receive a high priority.

A number of organisational and environmental characteristics were examined to identify any differences between the experimental and control groups which might have influenced the dependent variable. These were: the number of patients on the ward (where appropriate), number of patients for whom the observed nurse was responsible during the observation period, whether the observed nurse was in charge of the ward or nursing team, evidence of named nursing, availability of information about the setting to patients/clients, availability of information about the Patient's Charter and ward layout (where appropriate). Differences between proportions were analysed using the chi-squared statistic. No statistically significant differences were identified between the experimental and control groups on any of these variables for any of the observation periods.

8.3.4 Comparison of mean ratings for pre- and post-course observations

Mean ratings for each participant for each dimension were calculated by summing the ratings for each dimension and dividing by the number of valid events. Mean ranks between groups were compared using the Mann-Whitney U Test.

The results for the pre-course analysis are shown in Table 8.10.

Table 8.10 Mean scores for each dimension at baseline

Dimension	Mean score Obs 1	Mean score Obs 2	Mean score Obs 1 and 2	Z score	Sig.
CHOICE					
Exp.	1.51	1.33	1.42	-.4041	.6861
Control	1.51	1.64	1.58		
INFORMATION					
Exp.	1.94	1.93	1.94	-.1155	.9081
Control	1.86	1.93	1.90		
FEEDBACK					
Exp.	1.92	1.83	1.89	-.2887	.7728
Control	1.65	1.87	1.76		
RECIPROCITY					
Exp.	0.84	0.80	0.82	-.8085	.4188
Control	0.95	1.15	1.05		
PRIVACY					
Exp.	1.70	2.28	1.99	-.5540	.5795
Control	2.02	2.11	2.07		
PARTICIPATION					
Exp.	1.22	1.09	1.16	-.1157	.9079
Control	0.78	1.13	0.96		
INDEPENDENCE					
Exp.	1.84	2.00	1.92	-.1539	.8777
Control	1.87	2.15	2.01		
SAFETY					
Exp.	2.92	2.76	2.84	-.2341	.8149
Control	2.79	2.91	2.85		

This analysis suggests no differences between the groups at base-line suggesting that the matching procedure was successful in identifying similar groups.

The procedure for calculating the mean ratings for each dimension was repeated for the post-course observations and the difference between the pre-and post-course means was calculated

The analysis fails to reveal any statistically significant differences between the pre- and post-course measures on any of the dimensions of interest. Table 8.11 shows the change between the pre- and post-test observations scores for the eight dimensions. The mean ratings suggest an increase in scores for the experimental group on most dimensions. However, the differences in change scores between the experimental and control groups were all non-significant. The analysis therefore failed to provide statistical evidence of a differential change in pre and post test scores between the experimental and control groups i.e. neither group experienced a larger 'change' in scores in any of the eight dimensions.

Table 8.11 Differences in mean scores for pre- and post-course observations

Dimension	Mean score Obs 1 and 2	Mean score Obs 3	Diff	Z score	Sig.
CHOICE					
Exp.	1.42	2.09	+0.67	-7.551	.4502
Control	1.58	1.74	+0.16		
INFORMATION					
Exp.	1.94	2.25	+0.31	-1.3856	.1659
Control	1.90	1.91	+0.01		
FEEDBACK					
Exp.	1.89	2.30	+0.41	-1.5011	.1333
Control	1.76	1.87	+0.11		
RECIPROCITY					
Exp.	0.82	1.38	+0.56	-.8085	.4188
Control	1.05	1.11	+0.06		
PRIVACY					
Exp.	1.99	2.36	+0.37	-.5540	.5795
Control	2.07	2.27	+0.20		
PARTICIPATION					
Exp.	1.16	1.65	+0.49	-1.1209	.2623
Control	0.96	0.91	-0.05		
INDEPENDENCE					
Exp.	1.92	2.29	+0.37	-.4001	.6890
Control	2.01	2.43	+0.41		
SAFETY					
Exp.	2.84	2.82	-0.02	-.0291	.9768
Control	2.85	2.90	+0.05		

8.3.5 Analysis of observational field-notes As observational pilot work proceeded, it became apparent that the observational field-notes complementing the structured rating of each observed event would provide valuable data on the strategies which nurses could use to promote the independence and autonomy of older people in their care. Similarly, this qualitative data described a number of practices which appeared in direct contrast to the aim of promoting autonomy and independence. We decided to include an analysis of this data within this report as an additional product of the research. The data identifies specific examples of the theoretical dimensions of interest applied to practice, which could provide useful examples for educational materials in this field.

Procedure Field-notes for each event were reviewed by the observers as soon as possible following each observational period and corrected and annotated as necessary. One member of the team (SD) then reviewed the field-notes for each event and extracted fragments onto a matrix in relation to categories of behaviour. Field-notes for all the observational periods were analysed including those involving nurses for whom complete data-sets (i.e. six observations per pair) were not available. This data-set included field-notes from eighty-seven observational periods (more than 260 hours) with thirty nurses and included observation of more than 1500 separate care events.

Initially, no attempt was made to condense categories and a fragment was situated in more than one category if it appeared to represent more than one type of behaviour. As more general themes emerged, categories were grouped in an attempt to provide meaningful descriptions of nursing practice. Not surprisingly, the dimensions of the observational tool formed categories in themselves: however, additional categories also emerged and were listed separately. Consideration of the complete data-set including these new categories suggested the following themes:

- Negotiating care with older people
- Encouraging older people to do as much for themselves as possible
- Informing older people
- Promoting individualised care (not allowing the routine to dominate)

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- Recognising the 'personhood' of older people
- Avoiding controlling language
- Being alert to cues given by older people (verbal and non-verbal)

These themes are presented here in positive terms, although the data-set included a balance of examples of practice which both reflected and contradicted each strategy. Each major theme is described below and illustrated with selected fragments from the data. There are obvious areas of overlap and connections between these themes: for example being alert to verbal and non-verbal cues can ensure that care is negotiated. However, the themes are presented here as discrete entities in order to provide a basis for further discussion.

Negotiating care with older people This theme included categories related to choice, assessment, consent, compromise, feedback and participation.

There were many examples of nurses offering detailed choice to older people in the context of activities of daily living. The following extract was typical:

> *The setting is an acute EMI ward. The patient, a seventy year old lady with depression is worried that she isn't dressed. She is fairly immobile.*
> N Do you want me to put your clothes out for you?
> *Patient agrees. The nurses chooses clothes with the patient and complements her on them. The nurse suggests that the patient can go to breakfast with her nightie and dressing gown on if she wants to.*
> P I'm a nuisance
> N No you're not at all

There were also numerous examples of the nurse negotiating the extent and type of help that would be given.

> *P explains that she may need some help with a wash due to minimal use in her right arm*
> N No problem. Would you like a bowl to start?
> P Yes please
> *Go through what P would like to put on. N fetches water.*
> N Would you like me to help?

Acute medical ward. Eighty-eight year old male patient asks to transfer from toilet to wheelchair.

N What would you like me to do?

Patient explains that he wants nurse to pull his trousers up. Nurse does exactly as patient asks. Patient transfers himself. Nurse checks whether he is OK and comfortable in wheelchair.

Negotiation with older people who are confused can be particularly challenging and there were examples of skilled communication within this context:

Acute medical ward. Ninety-four year old lady, mildly confused. Asks nurse if she can go back to bed.

N Do you want your tea first?
P I've had my tea
N No not yet
P Can I go to bed?
N Well what about your tea what do you think?
P Oh yes *(cuddles nurse, nurse cuddles her back)*

However, there were also numerous events when the observed nurse failed to negotiate care or offer choices which the observer felt were appropriate and feasible within the context of the event. There were some examples of nurses denying patient choice, for example in insisting on patients getting out of bed or having a wash. In some instances, choice was 'unconsciously' denied because the nurse failed to allow sufficient time for the older person to respond to a question or express their preference:

N You'll not get better lying in bed - come on leap out!

N Do you want to powder yourself? *(Didn't wait for reply - did it for patient.*

Important aspects of negotiating care with older people include assessing their needs and attempting to elicit feedback on care given. Surprisingly few examples of nurses asking older people how they were feeling were recorded during the observations. In particular, most nurses failed to make any sort of verbal assessment during drug administration. One participant asked all patients whether they had any pain but this was a notable exception.

Awareness of the importance of gaining consent from the older person was apparent for some respondents. In some instances, this related to recognising the older person's right to control access to their own personal space and possessions, for example asking the patient's permission before looking in their locker or drawer. For one of the wards included in pilot work, this practice extended to patients' notes with staff seeking a patient's permission before looking in the personal files kept at the end of each bed.

However, observers also noted a significant number of events where respondents failed to negotiate consent, particularly in relation to direct care-giving.

> *N removed sheets when washing without asking consent*
>
> *Epileptic patient given medication covertly in breakfast for ? reasons of safety*
>
> N I'm going to give you a wash

On some occasions, participants appeared to be making a token attempt to gain consent but either did not follow this through or used language which did not suggest a willingness to negotiate:

> N Can I take your pulse *(didn't wait for reply)*
>
> N Lets take the blankets down

There were obvious dilemmas for nurses when patients were unable to provide informed consent. In a small number of events the use of physical restraint was observed in an attempt to minimise risk or ensure necessary treatment:

> *Setting - opthalmic ward. Female patient aged 93 with senile dementia, awaiting cataract extraction. N woke patient to prepare for theatre. Patient became quite aggressive. One nurse had to hold patient's hands while a second nurse put eye drops in. Nurse apologised to patient throughout and repeatedly explained the need for the drops.*

The nurses involved in this incident were themselves distressed and expressed their concerns to the observer about the decision to operate on this lady, which they felt was inappropriate.

During one observation period, nursing staff on a mixed rehabilitation ward decided to keep a male patient with dementia in his pyjamas in case he tried to leave the ward. There was no attempt to negotiate this subtle form of restraint with either the patient himself or his family.

Informing older people Providing older people with adequate information in ways that they can fully comprehend is a pre-requisite for autonomous decision-making. Furthermore, providing information, instructing and educating have been identified as interpersonal skills which are highly valued by patients (Fosbinder 1994). The observers were particularly alert to opportunities for information giving and education and some practitioners appeared very skilful at incorporating these strategies into daily care activities. Information giving formed a discrete dimension within the observational tool and there were numerous documented examples of nurses explaining procedures. Some participants appeared highly skilled in this area, providing a running commentary on their activities for the older person and keeping them informed of what they were doing throughout each care event. However, there were also numerous events where participants missed opportunities for information giving, particularly in relation to drug administration and observations:

> *Acute medical ward. Patient complained of central chest pain and nausea. N fetched GTN spray and gave to patient*
> N I'll just give you this to try and relieve your discomfort. Have you had it before?
> *No response from patient. Sprayed twice. No explanation of what it was, what it did, side-effects, where it would be sprayed etc.*
>
> *EMI ward*
> N Are you going to come in for your tablets J.
> P How many is there?
> N There's just three
> P There don't seem to be so many
> N Well its no good having a lot if they're not doing you any good is it.

> *Triage nurse in A&E. Patient admitted following a fall. (Aged 87) No information given other than where to sit and that a doctor would see her.*
>
> *N measured blood sugar. Social interaction throughout procedure but did not tell P the result. Next patient same procedure. Did not tell patient result.*
> P Is it good? Is it more stabilised?
> N Yeah (no further response)
> *Returned to patient later (30 mins) and did then reassure P about the blood sugar result*

In some instances, inaccessible language likely to be incomprehensible to the older person was used:

> N Your hemi legs a bit swollen but it's always been that way
>
> N *(inspecting wound)* I'll have a word with our tissue viability nurse - right babe?

On occasions nurses provided information too late to be of value to the older person. This occurred particularly when helping an older person to move. Repeatedly, nurses were observed telling an older person that they were moving them *as they were carrying out the procedure*, with the result that the older person frequently looked startled and disorientated. The following descriptions illustrate the contrast:

> *N dragged chair to basin with patient sat on it. No warning. Patient looked alarmed.*
>
> *Lifting patient up bed with sheet. Didn't really explain what she was going to do*
>
> *Moving using hoist from bed to chair. Gentle handling. Explanation throughout. Consistently concerned that patient is aware what is happening throughout.*

In the opinion of the observers, numerous opportunities for patient education were missed, particularly in relation to the administration of medicines. In some ward settings, nursing auxiliaries and health care assistants were involved in drug administration. The observed nurse checked the medication and gave it to the nursing assistant who then took it to the patient. As a result, opportunities for assessing the older person's needs, informing them about their drugs and encouraging self-medication were lost.

Encouraging older people to do as much for themselves as possible A third theme related to encouraging older people to be as physically independent as possible. There were some examples of nurses identifying strategies which would help the older person to optimal independence:

> *N encouraged P to do up buttons on sleeve. P struggling*
> N The OT has some things for helping with buttons
>
> *N encouraged patient to do as much for herself as possible and reassured her that it didn't matter how long it took her*

However, the field notes also documented numerous missed opportunities for encouraging an older person to do as much for themselves as possible, for example:

> *N could have asked patient to wash own teeth*
>
> *N dressed patient and fastened jersey zip. Pulled up trousers. No attempt to assess what patient could do for himself.*
>
> *N spread marmalade on toast - patient could have done this herself*
>
> *N didn't ask patient if she wanted to put nebs* (nebulisers) *in herself. Patient self-medicating at home*
>
> *N brushed patients hair - could have brushed it himself Dressing patient. Not encouraging him to dress himself.*
>
> N I'm just going to wash your back while I'm here cause you can't do that for yourself can you.
> *Started to wash front ? unnecessary*

The balance between negotiating care and encouraging an older person to do as much for themselves as possible is a fine one and many of the observed events suggested that nurses are sometimes prepared to sacrifice short-term autonomy in the interests of longer-term rehabilitation. It was surprising that we observed so little interaction and team-work in the context of day-to-day care between the many different disciplines involved in caring for older people This was particularly noticeable between nursing staff and therapists. It seemed that, if an older person was scheduled for treatment from a therapist, then the nursing staff either left them alone or rushed to get them washed before the therapist arrived, who then took over. The following event was a notable exception.

> *Acute medical ward. N and physio are helping patient to walk from one chair to another. N encourages patient to push herself up from chair. Physio explaining how to use Zimmer frame.*
> P	I could do with a brandy. *All laugh and agree.*
> *Gave patient time to mobilise, no rushing. Encouraged to move frame herself. Both praise.*
> N	You've got a gold star for that

Recognising the individuality and 'personhood' of older people This theme included categories of nurse behaviour which appeared to acknowledge the older person as an equal and valued human being. In some instances this was demonstrated in the terminology used to address the older person. On a very few occasions, participants addressed older people by their surname with the appropriate prefix. In most instances older people were addressed by their Christian name. However, in a significant minority of events, older people were addressed using impersonal ('sweetheart', 'duck', 'flower') and in some cases derogatory terms ('doll', 'babe').

A significant proportion of field-notes related to attempts to preserve the privacy and dignity of older people during care-giving. Within an institutional environment, opportunities for privacy are reduced and some participants seemed to be acutely aware of the need to protect the older person's right to personal space. Knocking on doors and waiting for a response before entering, waiting for permission to re-enter behind drawn curtains, approaching the older person and lowering the voice before discussing personal information, were all indicators of the sensitivity with which some nurses approached their work.

Conversely there were numerous examples of nurses failing to recognise the threats to personal dignity within a ward environment. Curtains left partially open during the most intimate of care procedures, toilet and bathroom doors left unlocked with no indication that they were occupied, older people encouraged to use the commode at the bedside without being offered the opportunity to be wheeled to the toilet. Such omissions of care were frequently observed. A further breach of personal privacy was observed in nurses' failure to lower their voice when discussing intimate details of care within earshot of other patients and staff:

N *(Within earshot of others)* Have you got any teeth - no you don't wear them?

N Do you want to go to the toilet? *(shouted across room)* which one this end or far end of the ward?

N Are you all right Lilian *(shouting through curtains)* Had a wee?

Attempts to protect the privacy and dignity of older people were particularly desirable given that nearly all practice settings in which the observations took place provided care for older people of both genders.

Some events suggested that the nurse objectified the older person to some extent failing to treat them as a thinking, feeling human being:

N *(to patient)* Right then that's one done *(referring to three patients in her care)*

N leaves patient hoisted in mid-air while looking for hair-brush

N doesn't look up from writing to ask questions - lack of eye contact

On some occasions, the nurse appeared to trivialise the older person's view

N evaluating care. P said she was scared of wetting the bed
N It doesn't matter
P It matters to me
N Does it happen sometimes?
P Only when I cough
N Well you can't help that can you (11.10)

EMI ward. Male patient aged 75 initiates interaction with nurse

P I need some money

N No you don't - you're in hospital. This is the NHS and you paid for this when you were younger *(end of interaction)*

Some nurses (a minority within the sample) appeared to stereotype individual patients, for example labelling them as 'naughty' or 'difficult' (Stockwell 1972, Johnson and Webb 1995). There were indications that such labelling had important consequences for patient care as illustrated by the following extracts. The exchanges took place between a staff nurse and a seventy-nine year old man admitted to an acute ward for assessment of abdominal pain.

N Morning love. Have you had a wash this morning?

P No

N We'll sort you out with a wash.
....what's the matter?

P I feel rotten *(Not picked up by N)*

Staff nurse left to get water. Nursing auxiliary approached P and asked if he had had a wash. Curtains were partially closed.
N returned with water.

N I'll help you up but I'll not pull you up because if I hurt my back...
Go back on your pillows

P No I want to sit up

N I'm going to wash your top and sit you out in a chair

P I were only washed yesterday

N I were only washed yesterday but guess what - I've had another wash today.

P You're mad

N If you don't have a wash you'll start to smell and you vomited this morning. Who washes you at home? *(No response from P)*
Continues with wash
You dry underneath that arm then you can do it properly.

P It didn't want all this

later N Are you going to pull your trousers up then I can pull the curtains back

P I keep telling you I can't go that bloody fast you keep rushing me...get out of the way I can do without you.

N Its not for nothing - I can't pull the curtains back until you're covered up we've got ladies on the ward.

later as leaving

N If you're feeling sickly - *(points to vomit bowl)*

P I'm sorry, I'm sorry

Although this patient was undoubtedly rude, the nurse engaged in a series of confrontational exchanges which appeared to exacerbate the situation. The patient seemed extremely anxious about his condition and was referred for an emergency ultrasound examination later that morning. At no time during the period of observation were his anxieties discussed with him. A further example involved a male patient in a side-room who repeatedly called for attention while seven nurses were gathered around the nurse's station for the shift-handover report. Generally acknowledged to be 'difficult' and 'attention-seeking', he was ignored for twenty minutes while the report was completed.

At the other extreme, there were numerous examples of nurses making every attempt to get to know the older person as an individual. Nurses taking the time to ask about an older person's previous life, their family and their plans for the future demonstrated a real interest in the person and suggested that the relationship also had value for them as a nurse. Some of the most apparently successful exchanges took place when the nurse appeared to have a detailed knowledge of the person concerned and demonstrated this in conversation with them. Humour was also skilfully and appropriately used on numerous occasions to put an older person at ease:

> *Acute medical ward. N admitting 69 year old male patient and checking details.*
> N Any allergies?
> P I'm perfect
> N All men say that *(both laugh)*
> P I'll have to go home - I don't like the cooking.
> N Why? I do the cooking!
> P Oh in that case I like it *(both laugh)*

Avoiding controlling language Lanceley (1995) has suggested that the use of controlling language emphasises the differential power relationship between nurses and patients and contributes to a sense of helpless dependence. We observed numerous instances of nurses using potentially controlling language with older people in their care. Some examples are listed below:

N Would you like me to help you with a wash?
P I've washed below
N No you haven't. There's your soap. Are you going to do your hands and face for me? There's your water

Infantilising/chastising

EMI ward. Nurse is introducing a visitor to a male patient.
N What is your name?
P Mr N
N That's right! This is Lucy - can you say Lucy?
P Yes
N Say it then.
P Lucy
N Well done!

Drug round - rehabilitation ward. Female patient, mildly confused.
N Will you take them for me please.
Just take them while I'm here then I can wash my pot.
Sometimes its necessary to make you better. I know nobody likes taking tablets

Male patient in hoist
N I'm going to wash your penis and scrotum
Hoist swinging - N blames patient
N Its you pushing against the hoist isn't it - pack it in Arthur.
Now lets wash your hands

'We' language

N Lets take your vest off and give you a fresh one

N Shall we move you now to the chair - we need to get you mobilising Mrs N

N What are we doing about a wash this morning?

Commands

N Nigel (N) got your tablets here *(shouted over top of drugs trolley)*
Handed patient medicine pot
N Take your tablets *(no explanation)*

N enters dining room
N Whose a feeder? (to other staff present)
Use your serviettes - don't spoil your jumper

Being alert to cues given by older people (verbal and non-verbal) This was a minor theme in terms of the number of events observed but significant in relation to the potential effect for the older person. It described events where the nurse appeared to respond to the older person's obvious anxiety, distress or desire for self-expression. In some instances, the observed nurse demonstrated advanced communication skills; for example:

> *P upset, crying, left the breakfast room. N caught up with her and asked her what was wrong. Gave time to cry and to go through her feelings. Talked about the weather and shared feelings about the snow and then moved on to how the patient felt about life. P talked about how she felt about her age, her lack of independence because of going into a home and that she felt her life lacked purpose. P said to the nurse "I love you" and gave her a cuddle. N cuddled her back and kissed her. P then insisted that N was to go for her breakfast and assured her that she would be all right. N said she would be back to check that she was OK.*

However, once again there were a similar number of events where the nurse failed to respond to such cues in a way that seemed adequate to the observer:

P I never thought I'd come to this *(Tearfully)*
N Yes and its a bit of a shock *(carried on with dressing)*

P Do you think use will ever come back? *(referring to effect of stroke)*
N Yes - I'm not saying come back 100% *(no further comment)*

P Should I be taking all these (tablets)
N You should yeah - its only what you normally have. I've checked your card.
P Its terrible all this *(No response from N)*

P I hate this wheelchair
N It'll help you get around

Rehabilitation ward. Male patient recovering following a stroke.
N Are you all right J? No pain?
P Yes I have
N Do you want anything for it?
P They won't help me
N You're not bothered then. *(End of interaction)*

Such events were sometimes recorded in the context of a busy shift with the observed nurse having to juggle the care of six or seven older people. However, just as frequently, these events were recorded with no obvious time pressures to explain the nurse's omission.

Promoting individualised care (not allowing the routine to dominate)

The effects of institutionalised practices on the well-being of older people have been well documented. Nonetheless, we observed numerous events where the individual needs of older people appeared to be subjugated to the normal routine within a particular care environment. For example, nurses frequently woke sleeping patients to give care or medication:

> *N woke patient to give medication*
> P What time is it?
> N Its still night time love but I've had to wake you up for your tablets. Would you like anything for your bowels?
> P No thank you
> N I've left them there for you (tablets). Don't forget them and drop back off will you. (29.11)
>
> *Acute medical ward. Nurse responded immediately to patient's request to use the toilet and helped her to walk. The patient, described as mildly confused, asked the nurse why she couldn't get dressed. The nurse explained that she was in hospital and said:*
> N You need to stay in your nightie in case the doctors want to examine you and then you'd have to take your stockings off.

On one ward, most patients were up and washed when the morning shift started at 07.15. The observer asked why this was and was told that the morning drug round was now carried out by staff on the morning shift to avoid possible errors by tired staff at the end of a night shift. However, this change in practice had led to the night staff taking responsibility for helping patients to get washed and dressed before the day shift arrived.

Routinised practices were frequently associated with 'the drug round'. Even where there were facilities to support a more individualised approach to the administration of medicines, for example individual patient cupboards or trays within a central dispensary, the ethos of the drug round persisted. Very few patients were self-medicating.

Rehabilitation ward. N checked controlled drug. Said that this particular patient liked to have her drugs early so gave at nine even though not due until ten. Approached patient with drug.
P I don't want to take them just now
N Oh you have to
P But its only half past nine.
N If I don't do it now it'll be ten o'clock before you have them. We have to follow our routine and then we don't make any mistakes (28.1)

Drug round, rehabilitation ward. N approached male patient who looked upset.
N Oh you're not going to cry for me tonight?
Patient burst into tears
N I've got your medicine for you. *Patient coughs.* Oh and you've got a bad chest as well.
Patient was lying flat and the nurse was trying to give him his tablets - he started to choke.
N *(helping to sit up)* come here flower - oh dear.
I've got a tiny little drop left in this pot - are you ready for it?
P No
N Well I've upset you good and proper haven't I.
Didn't you want a warm drink?
P No
N Will you have the rest - its only a tiny drop. Have a good swallow.
That's it, its gone the right way this time

This nurse was speaking throughout in quiet calming tones but appeared reluctant to leave the routine of the drug round in order to find out why this patient was so upset. She also seemed unwilling to interrupt the routine of the other three nurses on the ward who were busy settling patients for the night. She did return to the patient once the drug round had been completed. He seemed to have recovered, the bay was in darkness and the incident was not mentioned.

There was some evidence to suggest that older people themselves had become deferential to the routine:

N What do you want - breakfast or a wash?
P Yes anything that's no trouble to you
N I'll get you a nice chair to sit in

N Would you like your breakfast - there's porridge, toast with marmalade?
P Yes please. I'm not bothered about porridge - don't put yourself out making porridge
N You can have porridge if you wish - its not putting me out

On only a few occasions were older people observed to challenge nursing practice. The following extracts provide some examples:

> *Acute medical ward. Male patient aged 72, admitted with unstable angina. The nurse is 'doing the drug round' for her team of four patients. She informed the patient that she needed to get some aspirin from the stock cupboard as he usually had the ones that dissolve. The patient insisted that this was incorrect because he always swallowed his tablets whole. After remonstrating with the patient for about a minute the nurse said* 'Oh forget it' *and turned away. The patient said* 'I'm sorry'. *A few minutes later he asked me (the observer) to pass him his drug chart from the bottom of the bed which I did. The nurse then returned to the patient and asked him what he wanted to know. The patient then became quite agitated and said* 'Just a minute, I'm taking the drugs not you. You're treating me like a fool'. *The nurse then went through the drug chart with the patient and explained the doctor's decision to prescribe enteric coated aspirin.*

Nurse took tablets to patient who was struggling to eat his breakfast
N I've brought your tablets. Shift your arm - you're cutting your meat through your apron!
P I bet you don't talk to your dad like that
N I haven't got a dad, but I talk to my husband like that.

N preparing patient for discharge. Gave quite a lot of information verbally in relation to drugs (but did not explain what drugs were), GP letter and transport for follow-up appointment
N You'll have to be ready by eight o'clock, but your son will remember.
P **I'll** remember
N Oh you'll remember will you.

It is always difficult to assess the significance of fragments of data such as those included here when they are presented out of context. However, the three observers discussed each fragment and reached agreement on the type of strategy which it presented. We have tried to avoid making judgements about the practice we observed, but hope rather that these examples will cause practitioners and those responsible for their education to reflect upon what they might do to further promote the autonomy and independence of older people in their care more appropriately.

8.4 Interviews with nominated nurses and managers

Twenty nominated nurses, seventeen nurse managers and six course leaders (n = 43) were interviewed following the nominated nurse's completion of the programme ENB 941 programme Two nurses interviewed prior to commencing the 941 withdrew from the course; one due to ill health, the other overwhelmed by the volume and level of work required to successfully complete the programme. This nominee withdrew from the course immediately following the introductory day.

The main issues and themes which emerged during analysis of the post course interviews were:

- relevance of the ENB 941 programme to practice
- changes in practice
- individualised care

and

- attitudes towards older people.

These issues will provide the structure for presenting the interview findings.

Relevance of the 941 to practice All nominees felt that their knowledge had increased as result of the course but for some course members the relevance and applicability of material was at times limited. This was particularly the case for students working in mental health settings. For example;

> *...its quite generally based, the course* (around) *things like pressure sores.......I would have liked more* (on) *mental health.* (Mental Health)
>
> *...it (941) was more orientated towards general staff than mental health which, fair enough there were only two of us from the group from mental health, but even....down to the care plans there was nothing on depression....or psychosis or schizophrenia.* (Mental Health)

The same nurse went on to explain that general nursing also involved caring for patients who may be mentally ill:

> *I know there is a lot to teach but I think just even half an hour....on each* (condition) *would have been a benefit* (beneficial) *because obviously on the general side they are going to come across people with mental health problems, so I did find that a little bit of a shame, but overall it was OK*

Another nominee working in a mental health setting expressed similar disappointment. She felt that the course failed to cater for nurses caring for Elderly Mentally Infirm patients and drew attention to how nurses from different practice areas emphasised different aspects of care:

> *We've got time to do this* (encourage patients to feed themselves), *in a general ward sometimes that isn't important. What's important* (on general ward) *is ...getting people up, seeing to their treatments, seeing to their dressings, seeing to everything* (which) *might not be important to him* (patient).

A nominee from Mental Health described the value of having a course leader who was trained in mental health as well as general nursing, and how the group discussions would have been enhanced further had there been other mental health nurses attending the programme.

> *...because* (the course leader) *was psyche trained...we could bounce ideas off each other...It could have been more dynamic than it actually was...I wanted to join in and say well in my experience...but I'm not sure the others would have had experience,* (caring for patients with dementia) *particularly those from nursing homes...*

The relevance of a course to clinical practice was particularly important for this nurse. She described the benefits of attending a programme which encouraged course members to share aspects of their practice:

> *I think (nurses) are more motivated on a course which is relevant to* (the) *clinical area...and because it is the 941 its more specific...and you've got something to get to grips with and there's a lot more group discussion. I think its a lot more vibrant type of course*

One nurse manager suggested that while the ENB 941 was relevant to the practice setting she would have preferred to have access to a course dedicated entirely to rehabilitation:

> *I think its fairly relevant...the difficulty I'm in to be absolutely honest is that there is no other course and I'm just in the process of setting up* (a) *rehab course which from our point of view would be more appropriate than 941. I think the course that we need doesn't really exist at the moment so this* (941) *is the next best thing*

Changes in practice Nominees and their managers were asked whether the nominee had changed their practice as a result of attending the ENB 941. Most nominated nurses were unable to identify specific changes in their practice; however, the majority of the interviews took place immediately following completion of the course and this may explain the perceived absence of effect. Changes in practice were noted by some managers who described how former nominees introduced alternative approaches to care as a result of the course. For example;

> *We've changed the model of nursing......we've just started self administration* (medication*), these all came.....as a result of people opening their eyes and looking at what other possibilities there are..* (Rehabilitation).

Another manager working in a mental health setting described how, during a previous 941 programme, a nurse she had nominated introduced Pet Activity Therapy (PAT). As part of the admission procedure patients would be asked whether they had any pets and arrangements would be made to have the pet visit the ward every fortnight. She went on to describe the therapeutic value of PAT:

> *...some of the patients we don't get a lot of response from are really thrilled to bits with this. Often elderly people have had pets in the past and sometimes they have had to leave them behind or even on occasion put to sleep, because there has been no one else to care for them while they have been in hospital. They have had to go in a nursing home and the nursing home won't take them. That* (PAT) *was introduced from* (by) *one of my staff nurses during the course* (941).

Managers who had recently attended the 941 described how their practice had changed as a result of the course. For example:

> *I think one of the things that sticks out in my mind is I...on duty one night they'd had a lady I think who had been transferred from the ...* (local hospital)...(she was an) *extremely extremely* (emphasised) *noisy woman, and whereas before the course, as bad as it might sound, the first thing* (question) *would have been 'has she not been up* (prescribed) *any sedation', because she was really really causing disruption. After listening to things* (taught on the 941) *about the fact that the elderly are often wrongly prescribed drugs to sedate them, sometimes its the very drugs themselves that make them worse, and instead of trying to find out why...and trying to talk to the lady and looking in her notes. ...and that did stick out in my mind actually because before the course I would have been one of the worst offenders for grabbing the drug card and saying God, lets give them something!* (Rehabilitation).

A Senior Nurse Manager (Mental Health) explained how, as a result of the 941, she became interested in risk assessment and the use of cot sides. After completing the course, she surveyed patients and staff on their views about cot sides and explored alternative approaches to the prevention of accidents. She described how the course led to individualised care:

> *...my project within the 941 was... we used to use cot sides on everybody and I suddenly thought 'why do we do this?'. So that led onto the project being a questionnaire of staff and patients as to why we used cot sides, were there any other methods of stopping people rolling out of bed...led onto a particular interest onto why accidents happen...Some patients want cot sides because they felt safe and were used to being in a double bed at home, but other people felt trapped as if they were caged animals so the result of that was, it made nurses think, they didn't automatically put cot sides up. They asked the patient, they asked the relatives and if there was a risk from them rolling out of bed then they would explain it, but giving the patient the choice.*

Some course members described how, since completing the programme they had adopted a more holistic approach to the care of older people. One nominee explained how a session on sexuality and the older person helped her to manage an aspect of care which she had previously avoided:

> *We try and offer privacy just for the fact that they can be alone and the only thing that we can offer is just by drawing the curtains around the bed but*

> *that's all we have got really. One gentleman got quite embarrassed. I said 'What are you embarrassed for, you go and see to your wife, you just go and sit with her, hold hands, its nothing to do with me what you do. If you were at home It would have nothing to do with me so it shouldn't be here either.*

This nurse went on to describe how certain questions now formed an integral part of assessment and how she had learned to phrase sensitive questions;

> *...I have also asked about their sleeping arrangements. This was something I had never considered before. Say you have a patient who cant get upstairs, we will just bring the bed down. It wasn't a problem...I'm thinking about the safety aspect...but if they sleep in a double bed and they have got to purchase a single bed and they are going to be sleeping on their own when they have been used to spending all their married life together, I never considered that aspect whereas now I really do. I get around it as I have not actually been taught how to ask these questions and obviously people can be quite offended and embarrassed so I get around it by saying 'I appreciate this question is a bit sensitive but I need to get a full picture of what is going on at home, so we can plan your care.*

Some respondents mentioned how the course emphasised the need to be non-judgmental and that elderly people should have the same rights and choices as others; for example:

> *we covered homosexuality with* (and) *the older person. That was interesting. You find that a lot of older people that are gay do cover up, very good social cover because of discrimination, which is a shame. I'll give you a quote here...I really feel quite strongly about it. Sandra Mole in 1995 said 'Everybody has the right to have the choice of the person that they wish to love, heterosexuality and homosexuality are equal and therefore valid'. So who am I to say who you* (patient) *want to love. I wouldn't want anyone to tell me who I wanted to love.*

Individualised care Course members identified a range of taught sessions and approaches to learning which helped them to think about their practice. Of particular relevance were sessions on risk assessment and restraint. One nurse explained that in her everyday practice she regularly faced the dilemma of balancing patient safety and risk. This participant had learned that by informing relatives of the need to promote self care and the associated risks, they would be more understanding and supportive of the need to promote independence. She described her dilemma:

> *...you can get into a position of tension sometimes with some relatives in that they are saying 'why are people falling when they are in hospital?'... then it puts some people in a dilemma of whether you report the incident* (following a fall)*..you know whether you actually act on it properly, you know you should be allowing people to fall...some people should be allowed to* (fall) *you've got to weigh up economy against the right to walk round even though you* (patient) *are going to fall, but that needs discussion with people*
> (Mental Health).

Another course member described a taught session on restraint and her realisation of the forms of restraint that are used:

> *I found it a bit daunting really, looking at what you do, I mean looking at what is an act of restraint that you probably wouldn't think, you know like asking somebody if they wouldn't mind waiting for the toilet...You know if you are busy doing something else...like medicines, and somebody wants to go to the toilet and its the middle of medicine rounds and meal times...that could be... thought of as a form of restraint...not taking them."*

Approaches to learning which lead nominees to think about individualised care included the written component of the course, using reflective practice and focusing on critical incidents. For example one nominee described how reflective practice helped to provide the rationale for her practice: "*..reflective practice, seems a really good way of bringing theory into your practice"*. She went on to describe an incident which she explored within her learning portfolio:

> *I was his named nurse...*and *there was a complaint from his wife to the sister that he had missed his lunch because nobody had informed the day hospital on discharge...as a result* (following the incident) *I've gone on to look at clinical supervision and mentorship and how they may have helped prior to the complaint... And it had been left to an incident to highlight it rather than me looking in a reflective way at my practice and thinking perhaps I should be doing something...clinical supervision or a mentor would've...helped. ...I've been looking at Butterworth and clinical supervision...which I've never looked at before...I've read patients charter as well and the named nurse.*

Another course member described how the ENB 941 had drawn attention to patients rights, in particular the reduced level of autonomy and independence of patients in institutional settings:

> *I think that old age does reduce your autonomy...because you are old you don't have the empowerment and your power is taken away from you especially in institutions. We did to a certain extent try and get away from it but its not always feasible. We had one lady this morning - she had a CVA nine days ago and she's absolutely shattered...too tired...I asked her... 'what would you like me to do for you this morning, would you like a wash?' She said 'I would love a wash, and could you wash my hair?' I...said to her 'Are you up to it?' She said 'yes my head is itchy and I'm sure I would feel better'. I thought well fine, if that is what you want then that is what I will do for you....at the end of the day I am here for the patients and not for what I want to do.*

Another respondent explained how the course emphasised patient choice and the need to listen to an older person's priorities:

> *...listening to their choice...what they want to wear...would they like a bath or a shower, give them a choice, not just say 'you are going'...but to give them a choice...and time and space its very important. And when you get it right they seem to....respond.*

Attitudes towards older people Course members were asked which aspects of the programme had made the most impression on them. Sessions on ageism and stereotypical images of older people were mentioned frequently. In some instances course members felt the course challenged their perspective on the elderly and alerted them to negative attitudes, not only in themselves, but in others also:

> *.....you think you know a lot about the elderly but its (941) actually brought out a lot more - helping you think about what you are actually doing-not just yourself but everybody else around you...I'm stopping people now and saying, 'oy, do you know that's ageist.* (Rehabilitation)

This nurse felt that the programme had challenged her own stereotypical attitudes to older people:

> *It (ENB* 941)*makes you look at ...your nursing and...your approach. Not just at work but when out driving as well...now, when I'm driving along and you think 'old codger in front', now I think 'no, that's ageist! and stop myself....in everyday life its improved my attitude...where I live the population...are quite a lot older than us...you take more of an interest.* (Rehabilitation)

Other comments suggested that educationalists still have a long way to go in attempting to dispel ageist attitudes. One course member recalled comments made during a session on nutrition which involved planning a weeks menu for older people. This nurse observed that other members of the group seemed to think that everyone over 70 years had false teeth, tolerating bread and milk (referred to as pobs) and fish meals only. It is worth noting that a taught session on attitudes preceded the session on diets.

One course member from a mental health setting recalled the group being asked 'what springs to mind when you think about elderly people?' She described how she and most other course members found the session light hearted and humorous:

> *you're able just to come out and have a laugh about things that you know people do say, ...that they're old crumblies* (and) *they smell...obviously they're not true and don't think that I'm not caring...because that's not the case.*

Another course member, again from mental health, explained how the course consistently underlined the need to see older people positively and to challenge stereotypical images of ageing:

> *...we do perceive them* (older people) *in a very stereotypical way and realising and being aware that perhaps you are being ageist...because I think its one of those 'isms' that isn't discussed very much,...like racism...I think the underlying thing* (throughout the course) *is there is a definitely a positive approach to ...elderly care and I think that ran throughout the whole course*

8.5 Interviews with course leaders Course leaders to the ENB 941 programme (n=6), were asked how the programme helped course members relate theory to practice. Some course leaders felt that the role of the teacher played an important part in helping students make the link between the taught component of the programme and clinical practice. For part of their time these same respondents worked alongside practitioners in the clinical area. They stressed the value of supporting students in developing evidence based practice and introducing change:

> *...by using contemporary examples, by being up to date...I know that is simple to say but things have changed enormously...*(as a) *practitioner I spend...one day a week actually practising with a uniform on working alongside qualified staff to support their practice and develop their research based practice...one of the wards wants to develop collaborative care planning...another ward is developing self medication...so I am supporting that. That enables me to clearly relate things to practice when I teach because I have got absolute day to day contemporary knowledge.*

The same teacher described how knowledge, in the absence of real life clinical examples, made little impact on the students ability to influence practice:

> *We expect too much, we go in teach theory and we assume students can relate it to practice and I don't believe they can...we are teaching them all these things and they are feeling paralysed by the knowledge...we have got to help them get through...how they are going to problem solve and deal with it* (introducing change).

Another respondent made the point that as a lecturer practitioner their knowledge of the care of older people was based on real life examples and was therefore credible, something which was difficult to achieve using fictitious examples:

> *I tend not to get criticised by people* (course members) *they tend not to say that I don't know what happens in practice, because when something happens in A & E when something happens on the ward I can use it as an ...example, and I say on Monday in A & E so and so happened. And they love it, they love it...it is easier for me to give an example from practice than it is to try and think and construct an example, because you've got to be pretty clever to do that I think. To make sure it hits the mark...but ...I can do it from practice.*

Managing change formed a focus within some programmes, encouraging course members to apply knowledge using problem solving skills. However, one respondent, described how course members were not always in a position to change practice, and faced negative attitudes following successful completion of the course. This course leader recalled a manager's response to an attempt by a staff nurse to introduce a change in practice:

> *Oh don't come back here with your silly theories and your silly ideas. I'm doing this not out of malevolence I'm nursing and looking after these people and caring for people....don't come here telling me that I'm doing them harm...get back into your staff nurse boots.*

The same course leader expressed disappointment at the general lack of managerial support for course members post course explaining their want of interest:

> *...because they* (course member) *work with people who don't share the same thoughts as them - they work with people who think they've gone into some sort of intellectual vacuum'.*

The ad hoc process of selecting nominees for the 941 was also thought to be a reason why some course members failed to make effective use of the course:

> *it's a sort of lucky dip, one off each ward I suppose....we get quite a number of people getting sent on the course because they have their appraisal and need development either because they have a problem or because they have not performed..*

The introduction of the recently formed education consortia was thought likely to halt this practice, by placing more of an emphasis on the purchase of education which is practice:

> *I believe that won't happen anymore* (nurses sent on programmes for remedial purposes) *when they are buying from a Consortium because they will be buying them for a specific reason...the current system it was almost a case where we have six people to put on it* (the course) *whereas now they will be buying them specifically for what they need, certainly that is what we get at the moment.*

8.5 Summary of findings: Phase III

- Nurses in different care settings were able to identify a range of interventions for promoting the autonomy and independence of older people in their care, including individualised care, respecting an individual's wishes, information giving and encouraging participation in care planning. The significance of the nature of the nurse-patient relationship to the successful use of these interventions was apparent.

- Nurses attitudes to the nursing care of older people reflected a largely positive approach to the dimensions of choice, information giving, and to individualised approaches to planning and organising care. Attitudes to encouraging participation in care planning appear to be more variable and there was evidence that some nurses fail to see negotiation of care objectives as an important priority.

- Nurses identified barriers to the promotion of patient/client autonomy and independence. These included: lack of time and resources, attitudes of co-workers, ability and motivation of individual patients/clients and resistance to change.

- Observation of thirty nurses in a range of care settings and rating of specific events revealed wide variation in the extent to which individual nurses demonstrate an awareness of strategies for promoting autonomy and independence within their practice.

- Comparison of pre- and post-course ratings failed to detect a statistical difference in practice on the dimensions of interest between nurses who had completed the ENB course 941 and matched controls. There was however a trend towards increased mean scores on most of the dimensions of interest for the intervention group compared with the controls.

- Interviews with course members and their managers in three educational centres suggested that the ENB Course 941 successfully challenged stereotyped images of ageing and caused most participants to reflect upon their own practice, and that of their colleagues, in relation to the dimensions of interest within this study.

- Some managers and course members identified changes in nursing practice which they attributed directly to the ENB Course 941. These resulted mainly from the implementation of project work completed during the programme.

- Nurse teachers and some practitioners highlighted the importance of teachers developing close links with practice.

- It was not possible to conduct a randomised controlled trial within the context of this study. A quasi-experimental design with matched controls appears to be a feasible and practical alternative but requires a multi-centre study and a time scale which will allow the generation of a sufficiently large sample, to be confident of detecting the effects of an educational intervention.

SECTION 3

DISCUSSION, CRITIQUE AND DEVELOPMENTAL IMPLICATIONS

Synthesis and evaluation

Devlopmental implications

Chapter 9 Synthesis and Evaluation

9.1 Introduction

In order to address the research questions identified by the English National Board, this study has adopted a three phase approach. The aims were to describe the nature of a range of educational programmes in the nursing care of older people and begin to identify outcomes for these programmes. The research has combined qualitative and quantitative methods to collect data from a range of sources. Within this chapter a discussion of the extent to which the study has provided answers to the original research questions will be followed by a critical evaluation of the research methodology.

9.2 Discussion of main findings in relation to the research questions

Although the research design involved three separate phases each with a distinctive work plan, there were obvious areas of overlap. Within this discussion, the evidence from each phase of the study is synthesised to suggest implications for the future development of nurse education and practice in the care of older people. These developmental implications are summarised in chapter 10.

The nature and effectiveness of nursing interventions for promoting older patients'/clients' independence and autonomy

Definitional imprecision in relation to the key concepts autonomy and independence abounds within the literature. Nonetheless, these concepts form the basis of guidelines for improving care for older people in both institutional and non-institutional care settings and are incorporated within tools for measuring the quality of nursing care. There appears to be a general assumption that personal autonomy and functional independence are universal goals of care for older people and indeed, this research is, to an extent, based on this assumption. However, an extensive review of the literature revealed important gaps in knowledge in relation to the extent to which autonomy and independence are important goals of care for **all** older people. A major limitation of previous studies in this field is the neglect of older people with a degree of cognitive impairment. There has been no investigation of whether autonomy and independence are important concepts to older people with dementia for example; nor does the literature provide firm evidence about the priority which older people would give to maintaining personal autonomy and independence in relation to other potential consequences of care-giving; for example feeling safe or feeling a sense of belonging. The findings of this study should be considered in the light of these gaps in knowledge.

A review of nursing literature provided empirical evidence of the positive effects for older people of a number of nursing interventions and strategies aimed at promoting personal autonomy and functional independence. These were: offering the older person choice in relation to day-to-day activities; providing information or explanation about care, eliciting feedback from the older person in relation to actions taken or care given, protecting and respecting older patients' and clients' privacy, promoting independence in the activities of daily living and encouraging participation in care planning. We also found some evidence for the therapeutic effects of attempts to demonstrate reciprocity within the nurse-patient relationship, for example through giving personal information and appropriate use of humour. The outcomes of these interventions for older people include higher levels of satisfaction with care, decreased physical dependency and a greater personal sense of control.

Our observations of nursing practice in a range of settings provided some examples of older people challenging nurses' failure to include them in decisions about their care or to provide adequate information. However, more frequently, we discerned a lack of expectation to be involved and a willingness to 'fit in' on the part of older people. On occasions we observed a 'resigned passivity'. These observations reflect the findings of other researchers (Waterworth and Luker 1990, Nolan 1994). Interviews with a small convenience sample of older people, reported in Appendix V, suggested that the dimensions of interest which emerged from the literature review are important to older people with recent experience of hospitalisation.

Pre-and post-registration educational programmes in England: course philosophy, design, content and teaching and assessment strategies in relation to the promotion of independence and autonomy

We were able to identify a degree of focus on the dimensions of interest identified from the literature review within most educational programmes. Exceptions were the notion of working in partnership with patients, clients and significant others and the management of risk. Although participation in care features as a key value within many course philosophies, we were unable to trace the development of this theme within course content for most programmes. The notion of risk appears to feature in the content of some programmes but in general, is not specifically related to decision-making about the need to balance an individual's autonomy with an acceptable degree of risk. Furthermore there is little information on ways in which course members might be encouraged to operationalise these broad aims within their practice. For many programmes, autonomy and independence are identified as core themes forming 'threads' running throughout the course content. More specific reference to ways in which nurses might promote autonomy and independence for the older person may encourage the application of theoretical and philosophical ideals within nursing practice.

The majority of programmes included opportunities for course members to negotiate course content and assignment topics. This may be significant since there is some evidence to suggest an association between student-centred teaching and patient-centred practice (Rolfe 1994).

Both the survey of course leaders and the analysis of curriculum documents suggested limited consideration and awareness of the way in which individual programmes relate to, or build upon, each other. This is likely to result in overlap and lack of continuity for some students. The identification of educational pathways may enhance the availability of information in relation to the appropriate combination of programmes or modules for practitioners developing a career in the care of older people.

A recurrent theme is the need to strengthen links between theory and practice. Comments in relation to programmes with a clinical component suggested the need to increase length of placements and extend teacher availability within clinical areas, both to work with practice teams to develop practice and to help practitioners to apply knowledge and skills gained during a programme. Course leaders highlighted difficulties for students in returning to practice settings and facing opposition to change from practice colleagues. The role of link teachers in facilitating practice change was identified.

There was very little evidence of opportunities for shared learning between disciplines, even within the focused courses. This is surprising given the importance of a multi-disciplinary approach in meeting the health needs of older people. In contrast to the lack of opportunities for shared learning, some programmes included an enormous number of non-nurse contributors. It is doubtful whether the range of individuals identified can all be fully cognisant of the philosophy and objectives of the programme to which they are contributing and this raises questions about programme leaders' claims that autonomy and independence are themes threaded throughout the curriculum.

The lack of input to course development and implementation on the part of older people themselves is of concern. Current debate around user involvement in service planning centres around the representativeness of user groups and the difficulties of adequately representing groups such as those with mental illness or learning disabilities and those who cannot speak English. However, even though the most appropriate means of involving service users in the educational preparation of service providers has yet to be established, we would argue that the degree to which older people are currently involved in planning nurse education suggests that educators are less than fully committed to the notion of service user participation. There is a danger that this apparent lack of commitment gives the wrong message to students and will not encourage them to see service user participation as a priority. The recent publication of the ENB document 'Learning From Each Other' (ENB 1996) suggests that the Board are fully aware of this issue and its importance. This readable document provides guidelines and ideas for involving people who use services and their carers in education and training and deserves wide dissemination. Our findings support the need for the implementation of such guidance.

Programme evaluation is centred largely around student evaluation. There appear to be fewer opportunities for service providers and educators to evaluate programmes formally. The majority of programmes attempt to involve service providers in programme development but course leaders identified barriers to their participation. This is a recurring finding in ENB-funded research (White et al 1994, Thomson et al 1995) and is significant within the context of this study since service providers are able to offer a perspective on the needs of older people and are also aware of the realities of practice. Resolution requires enhanced collaboration between educators and service providers to identify pragmatic ways in which practitioners can contribute to programme development.

Overall, we were concerned with the lack of clarity within many curriculum documents. Most nurse educators would agree that enormous effort is invested in developing programme curricula and it is unfortunate that in some cases the fruits of this labour do not find clearer expression. Use of the phrase 'the elderly' which appeared in more than half the curriculum documents we examined, may have negative connotations and is disliked by many older people themselves. However to our knowledge the Board currently offers no guidance on the use of non-sexist, non-ageist terminology within course documentation.

The association between continuing care nurses' educational preparation and residents' quality of life

Findings from a national survey of nursing homes revealed wide variation in the proportion of staff with pre- and post-registration educational qualifications. Furthermore, within the majority of nursing homes, only a small minority of staff were undertaking any form of continuing professional education at the time of the study. These findings are noteworthy given the associations which we found between the educational preparation of staff, the proportion of nurses undertaking CPE and resident autonomy.

There are a number of potential explanations. The vast majority of nursing homes within the sample were managed as private enterprises and it many be that owners are unwilling to support the financial cost of CPE for staff. Where educational opportunities are provided, it is probable that these are directed towards the most senior nurses within the home with a view to encouraging these individuals to 'cascade' information to other employees and indeed there was some evidence from our interview data to support this notion. Most nursing homes appear to have very limited contact with Schools and departments of nursing and it is possible that information on educational programmes and events is not readily available. Furthermore, only one third of homes currently provide placements for nursing students. A number of studies have demonstrated the importance of responsibilities for student preparation in motivating qualified nurses to seek opportunities for continuing professional education (Hallett et al 1992, White et al 1994, Thomson et al 1995). Finally, many staff employed within nursing homes work part-time and are likely to have family commitments. While we did not seek information on the ages of all staff employed, the mean age of respondents (i.e. the senior nurse within each facility) was 45 years. A study of the educational needs of qualified nurses employed in nursing homes in Trent Region (Morrell et al 1995) found a mean age of 42 years (n=203). This 'mature' group of nurses may consider that their days of training and education are over and may experience anxiety at the prospect of academic study. Certainly the small number of nurses we interviewed who were employed in the private sector described enormous anxiety in relation to the academic workload of the ENB 941 programme. Conversely, nurses in the Trent study were able to clearly articulate their training needs, with bereavement counselling, management of pain and lifting and handling emerging as priorities (Morrell et al 1995).

With the closure of continuing care wards in NHS hospitals, many educational centres are seeking to develop links with private and voluntary nursing homes with a view to offering student placements within this environment. Indeed there is some evidence to suggest that students may be exposed to more positive attitudes and appropriate practices within nursing homes than within long-stay hospital wards (Bowling and Formby 1991). Evaluation of students' experiences within teaching nursing homes in North America suggest that the slower-pace and less-threatening atmosphere of the nursing home facilitate effective teaching (Neil et al. 1982, Everett and Hooks 1985). Together, these factors suggest potentially beneficial outcomes for residents, staff and students of further developing links between educational centres and nursing homes within the private sector. The development of teaching-nursing homes would require the input of sufficient resources to allow the establishment of link roles and adequate preparation of staff. While there is some evidence about the costs of providing clinical placements to service providers within NHS settings in Sheffield (Lloyd Jones and Akehurst 1996), we are unaware of any empirical research which has calculated the cost of placements within a nursing home setting.

Effects of pre- and post-registration educational programmes on the knowledge, attitudes and practice of nurses working in a range of hospital and community practice settings

Although the study has focused upon the detailed evaluation of a specific programme of continuing professional education - the ENB Course 941, the final phase of the study provided some information about the relevance and effectiveness of nurse education in general for preparing nurses to work with older people. The baseline questionnaires and interviews with nurses working in a range of practice environments provided information on nurses' views about aspects of practice related to the care of older people and the skills which they feel need further development. During interviews, nurse managers were encouraged to reflect upon the relevance of a range of educational programmes for preparing practitioners to work in this field. Additionally, the observational data provided information about strategies for promoting an older person's autonomy and independence which, in the opinion of the observers, should be addressed within programmes of nurse education more rigorously than at present.

The observational ratings and field-notes suggest wide variation in the extent to which nurses engage in practices which might facilitate the autonomy and independence of older people in their care. While most nurses incorporate some degree of information-giving and attempting to gain feedback into their day-to-day practice with older people, they appear to be less skilled at involving patients and clients in decisions about their plan of care. Universally high scores in relation to the promotion of patient safety suggest that nurses may find it difficult to determine an appropriate degree of risk and may unwittingly be threatening the personal autonomy of older patients and clients as a consequence. This finding reflects the analysis of course curricula in Phase I of the study which suggested that the issues of patient participation and risk-taking are insufficiently covered within most programmes.

With regard to the specific identification of outcomes for the ENB Course 941 (Nursing Elderly People) we were unable to demonstrate any change in knowledge, attitudes or nursing practice following course attendance. There was however, a consistent upward trend in mean scores across most of the dimensions of autonomy and independence for course members when compared with a matched control group. With the exception of items relating to patient participation, there was a similar trend in the expected direction for most components within the self-completion questionnaire; however, this trend was also apparent within the matched control group. This may be due to the effect of testing. In fact several respondents commented that the questionnaire had caused them to think about issues which they had not considered before. It is also possible that contamination may have taken place between the experimental and control groups, particularly since most of the matched pairs were employed in the same practice setting. Course members may have discussed the content of the educational programme with their colleagues, resulting in a change within matched controls, although this is a less likely explanation given the range of staff working within most settings and the limited opportunities for contact between individual nurses.

Perceptions of course members, managers and teachers in relation to the effect of specialised educational programmes on nursing knowledge, attitudes and practice Nurses who had completed the ENB Course 941 and their managers were able to identify changes in knowledge and attitudes which they attributed to the educational programme. Some practitioners were also able to describe changes in their practice. In many instances, this resulted from attempts to implement project work completed during the programme within their own practice environment. However, all participants were able to identify barriers to improving care through changes in practice which may have limited the effects of the educational programme. These included the attitudes of other staff, in particular a resistance to change, and staff motivation within the context of major changes in service provision. For some this included the threat, and the reality, of redundancy. Some participants questioned the extent to which the programme prepared them to initiate and manage change, particularly since many nominees were 'junior' members within nursing teams.

From the nurses' and managers' perspective, the programmes evaluated within the study appear to be particularly successful in challenging stereotypical views of ageing. There was evidence to suggest that some participants developed the confidence to challenge what they viewed as unacceptable practice or the expression of ageist views by others. Students appreciated the diversity of teaching methods within the programmes and opportunities to learn from each other were particularly welcomed.

Some course members and managers were concerned about the relevance of the 941 to their own practice setting and identified a need for more specialist and advanced courses relating to specific aspects of practice with older people, rehabilitation for example. However, some managers questioned the need for a programme focusing on the specific needs of older people in the context of a shift away from a policy of age-related admissions. A substantial minority of course members felt that the programme did not adequately cover the needs of older people with mental health problems. These findings suggest a need for nurse educators to work closely with service providers in order to negotiate the most appropriate educational provision.

Investigation of the process of nominating nurses to opportunities for CPE indicates that there is no standard approach. In some instances, nurses appear to be nominated on a basis of convenience, sometimes shortly before a programme commences in order to avoid sacrificing a place. In such cases, opportunities to ensure that the programme will meet the needs of the student and the provider organisation are obviously limited. Interviews with nurse managers shortly after nominees had completed the programme suggested that few had identified opportunities to discuss the nominee's plans to utilise knowledge and skills gained as a result. Furthermore, few programme leaders appear to offer structured follow-up to students after course completion. It is likely that such follow-up, possibly in the form of clinical supervision, would facilitate opportunities for applying knowledge to practice.

There were some suggestions, both from the post-course interviews and the programme analysis of a tendency for nurse educators to focus upon abstract concepts and theoretical ideas in their teaching at the expense of practical suggestions for applying such knowledge within the practice setting. This confirms the findings of other work (Thomson et al 1995) and may reflect the reduction in time spent in practice settings by teachers of nursing following the reforms of pre-registration nurse education (UKCC 1986). There is an urgent need for nurse educators to introduce practical examples of ways in which the broad aims of promoting autonomy and independence for older people can be realised in practice. We would suggest that some of the examples described in the observational field-notes for this study could be developed into teaching materials in this respect.

9.3 Methodological review

Phase I The initial phase of the study attempted to identify the features of educational programmes in nursing which promote autonomy and independence for older people. Data from questionnaires completed by a national random sample of programme leaders was combined with information extracted from curriculum documents. A total of 77 programme leaders completed questionnaires and 69 curriculum documents were analysed in detail. The general approval of senior education managers to participation and the response rate of 76% to the questionnaire were encouraging at a time when schools and departments of nursing and midwifery are continuing to experience rapid organisational change. Many programme leaders included detailed and extensive comments, providing a rich description of a wide range of educational programmes. However, the precise identification of features of individual programmes which would encourage nurses to promote autonomy and independence remained elusive. Just as the notion of personal autonomy seems to defy definition within the literature, so operationalisation within programmes of education is inexplicit. Although responses to the questionnaire provided information on issues identified as relevant by the research team, there was little evidence of innovation in relation to the dimensions of interest. There are two possible interpretations: either there is limited content in relation to the promotion of autonomy and independence or the design of the questionnaire did not prompt respondents to articulate it. It is possible that the only method which would allow precise description of those features of educational programmes relating directly to the promotion of autonomy and independence is direct observation, a method which was not feasible within the resources available to this phase of the study.

The analysis of curriculum documents proved laborious and time-consuming, particularly since the dimensions of interest to the study were often not addressed explicitly, involving a detailed search of copious material. A content analysis of a sample of curricula was carried out by two researchers independently and cross-checked but it is possible that some differences in interpretation may not have been identified. Some of the programmes were due for re-validation and the course curricula were possibly out-of-date.

A further challenge to the interpretation of data in Phase I of the study arose from the small sample size, which made it difficult to compare types of educational programme. Nonetheless, some important themes and trends emerged from this phase of the study, with implications for the future development of educational programmes for the care of older people.

Phase II In order to explore the association between the educational preparation of nurses and the degree of autonomy and independence experienced by older people receiving nursing care, a national survey of nursing homes was conducted. The data provide a detailed picture of the level and type of educational preparation for all nursing staff in a national sample of nursing homes and we believe that this is the first study to provide such information. The original intention to compare NHS and private provision of continuing care was thwarted by the decline of continuing care wards within NHS hospitals.

The scale used to measure resident autonomy was selected for its established validity and reliability within continuing care settings. Time precluded revalidation within the context of the current study and it would appear that conditions have improved within private sector nursing homes in the five years since the tool was developed. This has affected the sensitivity of the instrument with the result that the responses were highly skewed to the positive end of the scale. Since many of the items related to structural characteristics of the nursing home such as the existence of separate toilets for men and women, features over which most nursing staff might have limited control, we devised an additional scale comprising the eight items over which nurses might have more influence. However, responses on this sub-scale were also highly skewed with nearly all the variability explained by one item.

Nonetheless the survey data provided support for our primary hypothesis that there would be a positive association between the overall educational preparation of nursing staff in nursing homes and quality of care as indicated by the measure of resident autonomy.

Phase III The original intention to conduct a randomised controlled trial to determine outcomes for the ENB Course 941 (Nursing Elderly People) faced a series of challenges which eventually proved insurmountable within the time-frame of the study. These challenges are described in detail in chapter 6 of this report. The revised research design used a quasi-experimental approach to compare outcomes for nurses undertaking the ENB Course 941 with nurses matched on the criteria of age, sex, practice setting and educational preparation. However, even with this revised approach we found it impossible to generate an adequate sample. The design relied upon nurse managers identifying nurses who would be nominated to undertake the 941 programme at an early enough stage to enable us to negotiate each nurse's participation and collect baseline data before the programme commenced. Even where this process proceeded smoothly, managers often found it impossible to identify a nurse who matched on all the necessary criteria. We were seeking to generate our sample from four educational centres offering the ENB Course 941. The potential pool of recruits during the time-frame for this phase of the study numbered 114. However, we were only able to recruit 40 matched pairs to the questionnaire evaluation and 15 matched pairs to the observational component. Withdrawal from the programme due to personal reasons such as illness and non-return of questionnaires further reduced the sample for whom complete data-sets were available. The probability of identifying statistically significant differences between the two groups was therefore much reduced, because of the small sample size and subsequent reduction in power.

In the absence of existing tools to measure the dimensions of interest, the research team developed two instruments: a self-completion questionnaire to identify knowledge, attitudes to the nursing care of older people and intention to behave, and an observational rating scale to 'measure' practice in relation to the dimensions. Although these scales appear to have face validity, further research is required to establish the formal psychometric properties of both instruments. The self-completion questionnaire provided insight into nurses' attitudes towards the nursing care of older people and we would suggest that this is a more meaningful and appropriate focus than attempting to measure attitudes towards older people per se.

The maintenance of detailed field-notes in relation to each event allowed the observers to discuss and agree ratings following each observational period and has also provided a rich source of complementary data. We believe that these field-notes provide vital information for interpreting the complex interactions and events which were the focus of our observations. This may simply reflect the stage of development of the research instruments and the need for further development and pilot work before the tool can be used to 'measure' aspects of nursing practice. An alternative explanation is that the interactions and events which are the essence of nursing practice are so complex that it is inappropriate to attempt to reduce them meaningfully to points on a rating scale in the absence of supporting information. We would suggest that the method we used to observe and record practice was both feasible and practical, and produced data which was more meaningful than either numerical ratings or descriptive field-notes alone.

A further limitation of the experimental phase of the study was the assumption of a standard intervention. Although the ENB provides guidance for educational institutions in relation to the development of the ENB 941 programme, analysis of the curricula for the four programmes which were evaluated as part of this phase suggests that they were not strictly comparable. Furthermore, the small sample did not allow comparison between centres.

The interviews with nurses undertaking the ENB Course 941, their managers and course leaders complemented the experimental evaluation and provided some illumination in relation to the apparently limited impact of the programme. Because of the short duration of the study, interviews were carried out shortly after completion of the programme when any impact may not have been fully realised by the participants and particularly by their managers. Participants within this phase of the study are the focus of a longitudinal evaluation being conducted by a member of the research team (LE). Further interviews at six-monthly intervals until eighteen months after course completion will contribute to our understanding of the real impact of the programme.

9.4 Empirical and conceptual overview

In retrospect, the aims and objectives for this two year project were undoubtedly ambitious. The complex links between education, knowledge, skills, characteristics of the recipient of care and nursing practice require detailed and long-term investigation if the nexus of influences and outcomes is to be fully understood. Similarly, the study took place during a period of tremendous change, both within the establishments providing and influencing education for the care of older people and within the organisations providing services. However, such on-going change is a constant reality

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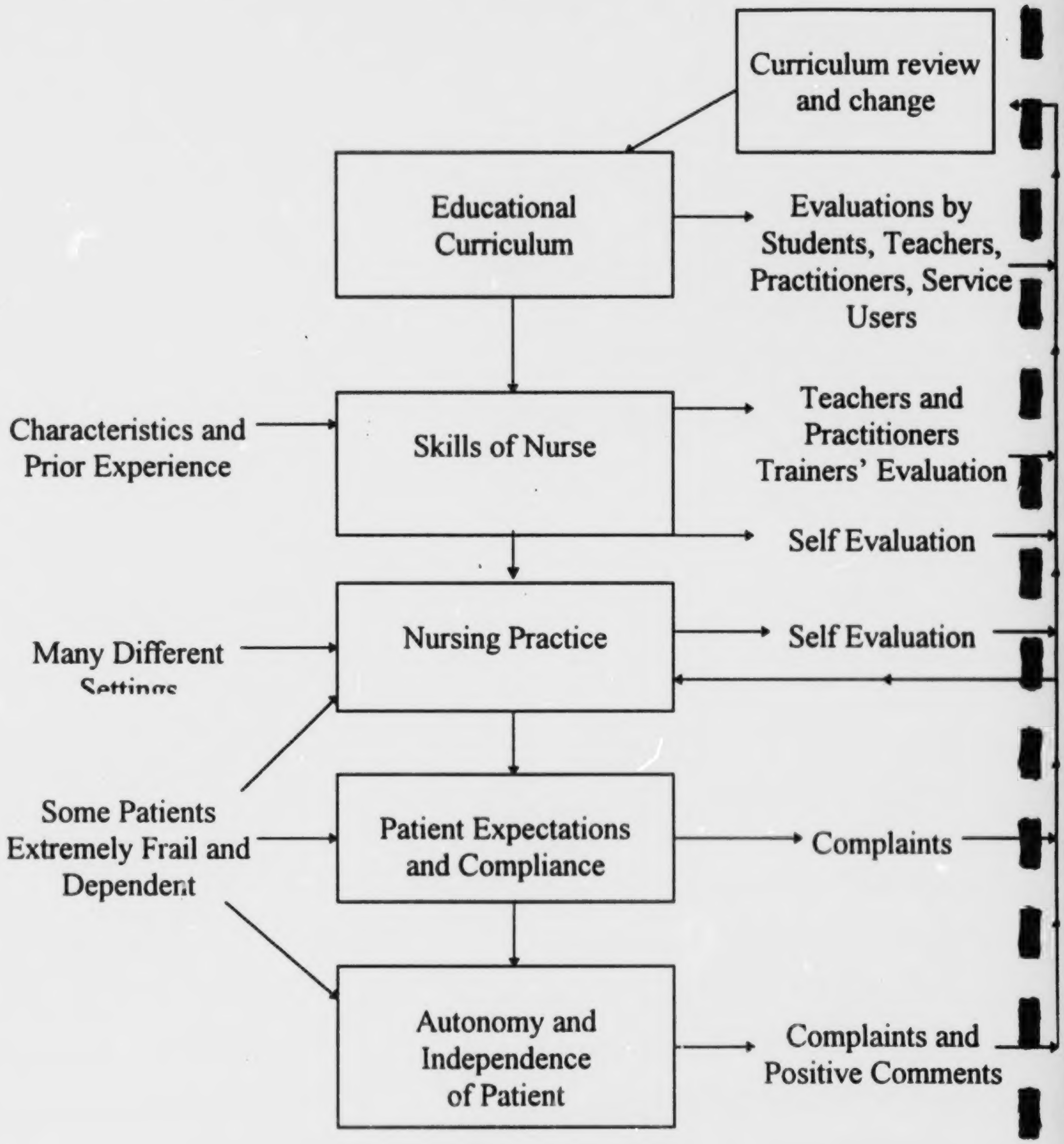
within the context of health and social care. Researchers must therefore tailor and adapt their methods to reflect the influence of these various changing factors.

This study makes an important contribution to an understanding of the multi-faceted influences on nursing practice and the consequences of nursing interventions for older people. Some of these factors are summarised in Figure 9.1. This conceptual model highlights the complexities of attempting to identify the influences of a curriculum change on nursing practice.

The imperative to establish relationships between education and practice suggests the need for a prospective longitudinal study over a long period of time with a large sample. Recruits would be contacted each year and asked to provide information on their education and work experience during the intervening period. At yearly interviews, participants would complete a multiple choice type questionnaire similar to the instrument developed in Phase III of this project, and designed to measure attitudes to nursing practice with older people. A sample would also be selected for in-depth interviews and practice observation. Such a study would allow an informative analysis of variance among major groups, characterised by the nature and intensity of their training and different kinds of work experience.

The influences of older people themselves in determining the extent to which they exercise their right to autonomy and independence should not be underestimated. There is an obvious danger that nurses encourage passive acceptance through their communication and actions with older people and these relationships need further exploration. An increased focus on empowering and facilitating older people within educational programmes in nursing may provide a catalyst to change.

Figure 9.1 Factors influencing the autonomy and independence of older people receiving nursing care


Curriculum review and change
Educational Curriculum
Evaluations by Students, Teachers, Practitioners, Service Users
Characteristics and Prior Experience
Skills of Nurse
Teachers and Practitioners Trainers' Evaluation
Self Evaluation
Many Different Settings
Nursing Practice
Self Evaluation
Some Patients Extremely Frail and Dependent
Patient Expectations and Compliance
Complaints
Autonomy and Independence of Patient
Complaints and Positive Comments

four major steps

multiple feed-backs

Chapter 10 Developmental implications arising from the research

The study findings have implications for the future development of nursing education, practice and research. For clarity we have grouped our recommendations under four headings:

- identification of educational needs
- development of educational programmes for the care of older people
- development of links between educational centres and practice environments
- evaluation of educational programmes

IDENTIFICATION OF EDUCATIONAL NEEDS

The variation in objectives and content in programmes of education leading to the same qualification and the range of educational needs identified by practitioners and service managers who provide care for older people in diverse care settings suggest that:

1. Service managers and educators should be encouraged to introduce and develop systematic approaches to the identification of educational needs for groups of nurses who work in the principal care settings

1.(i) Nurse teachers should work closely with service managers and practitioners to improve the translation of individuals' needs for professional development into programme objectives.

1. (ii) Given our finding that some nurses were unaware of programme objectives before they began, we recommend that information about the objectives and requirements of educational programmes should be readily available to all participants well in advance.

DEVELOPMENT OF EDUCATIONAL PROGRAMMES FOR THE CARE OF OLDER PEOPLE

2. Nurse educators should liaise more closely with service managers to identify the most appropriate forms of educational provision to prepare nurses to work effectively with older people

2.(i) In particular, nurse educators should explore with service providers the need for specialist advanced programmes to develop skills gained from the adult and mental health branches, ENB 941 and 298 programmes.

3. Educational centres should be required to demonstrate that service users and practitioners have been actively involved in the development and evaluation of educational programmes which incorporate a theoretical or practice component relevant to the care of older people

3. (i) Nurse educators should seek to develop innovative and practical ways of involving service users and service providers in programme development and evaluation.

4. There needs to be an increased focus on involving patients and clients as partners in care and on responsible practice in relation to risk and safety within the content of all educational programmes relevant to the needs of older people

4. (i) All programmes aimed at preparing nurses to care for older people should incorporate content relating to the development of advanced inter-personal skills and the management of change at both a personal and an organisational level.

5. Programme leaders should ensure that there are opportunities for course members to negotiate content and course-work so that they are more relevant to practice.

5. (i) In the design of project work, there should be a strong representation of exercises designed to exemplify theoretical understanding.

5 (ii) Students should be encouraged to identify issues of relevance to their own practice setting and have routine opportunities to suggest to course teachers, projects and assessments which have a direct relevance to these issues. A commitment to the implementation of the findings of project work on the part of service managers would increase the likelihood that knowledge gained during an educational programme results in practice change where appropriate.

6. Programme leaders for specialist programmes for the care of older people, in particular the ENB Courses 941 and 298 should ensure that the curriculum covers the needs of older people with mental health problems

6 (i) If programme leaders do not have a qualification in mental health they should seek the involvement of a specialist mental health practitioner or educator in programme development and delivery.

7. While it is appropriate that the concepts of autonomy and independence should form recurrent themes within curricula, it is vital that they should also be addressed specifically in those elements dealing with caring for older people.

7. (i) In particular, nurse educators should provide clear examples of interventions intended to promote an older person's personal autonomy and functional independence. Examples drawn from the direct observation of practice, such as the material presented in Chapter 8 of this report, could be developed into teaching material for this purpose.

8. Given the range of personnel who contribute to meeting the health and social needs of older people and the importance of multi-disciplinary collaboration to

individualised care, there should be increased opportunities for multi-disciplinary education and shared learning between professional groups.

9. The English National Board should offer further guidance to curriculum planners on the development of curriculum documentation, particularly with regards to the use of non-ageist terminology.

LINKS BETWEEN EDUCATIONAL CENTRES AND PRACTICE ENVIRONMENTS

10. Nurse educators and service providers should seek to enhance the effects of education on nursing practice through regular clinical supervision and performance review.

10 (i) Programmes which do not have an assessed practice component should be reviewed to explore the possibility of incorporating an element of clinical supervision with some direct observation of practice and debriefing.

11. Centres offering programmes of nurse education with a focus on the needs of older people should develop closer links with nursing homes, particularly those in the private sector. This is important in the context of declining continuing care provision within the NHS, and impending reduction in local authority direct provision.

EVALUATION OF EDUCATIONAL PROGRAMMES

12. The English National Board should continue to commission research incorporating a wide range of approaches in order to determine the outcomes and effectiveness of programmes of nurse education

12. (i) While experimental approaches can provide useful information on the effects of education on knowledge, attitudes and nursing practice, those commissioning such

research within an educational context should take into account the time-scale required in order to allow the generation of a sample. Data from experimental research to evaluate programmes of nurse education should be complemented with information on the views of course participants, service managers and service users.

12. (ii) The English National Board should consider commissioning a prospective longitudinal evaluation to examine the relationship between education and practice for the care of older people. Over a period of five years, the research would use questionnaires, interviews and observation to analyse variability in attitudes and practice in relation to education and work experience. The tools developed within the current study could be further refined for use within such research.

13. The English National Board should consider commissioning research to identify strategies by which nurses can identify the appropriate balance between promoting the autonomy of older people with mental health problems and minimising risks to safety.

13. (i) An initial exploration of this question could ask nurses to identify actual care dilemmas and describe characteristic resolutions, together with potential implications for the older person. The optimality of these resolutions could then be assessed by more experienced nurses.

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APPENDICES

I Summary of methods used to review the literature

II Course Leader Questionnaire (Phase I)

III Curriculum Document Checklist (Phase II)

IV Questionnaire to Continuing Care Facilities (Phase II)

V Additional tables (Phase II)

VI Interviews with older people carried out to inform the development of research tools (Phase III)

VII Questionnaire for nurses working with older people (Phase III)

VIII Observation schedule and criteria for use (Phase III)

IX Additional tables (Phase III)

X Interview Schedules used with Course Members, Managers and Teachers

APPENDIX I

Summary of methods used to review the literature

Methods for literature review

Computerised literature searches were carried out on the following databases: CINAHL, MEDLINE, ASSIA, Kings Fund and RCN. Searches used a series of combinations of the following text words: elderly/older people, nursing, nursing practice, nurse education, autonomy and independence

The following journals were hand-searched for 1995 and 1996:

British Journal of Nursing
British Medical Journal
Health Visitor
Journal of Advanced Nursing
Journal of Clinical Nursing
Nurse Education Today
Nursing The Elderly
Nursing Standard
Nursing Times
Quality and Health Care

The database of references were further developed using an incremental approach , examining the list of references for each paper retrieved.

Guidelines and policy documents relating to the nursing care of older people were accessed. Incremental review was carried out for these also.

Bibliographic details were entered onto a database (Idealist). A systematic approach to the review of each item involved identification of the key features including: main themes, boundaries (e.g. population and sample), methods, findings, conclusions/claims and methodological/theoretical critique. These details were also entered onto the database for each item. This process allowed the easy identification of items relating to each theme and comparison between items.

APPENDIX II

Course Leader Questionnaire (Phase I)

EVALUATION OF PRE-AND POST-REGISTRATION EDUCATION TO PROMOTE THE AUTONOMY AND INDEPENDENCE OF OLDER PEOPLE: AN ENB-FUNDED PROJECT

University of Sheffield

COURSE LEADER QUESTIONNAIRE

Please complete the questions as best you can. The information is collected exclusively for research purposes: nothing will be passed to any individual or body. It will be scrupulously protected as strictly confidential: no reference to identifiable individuals or organisations will be made.

This study is supported by the English National Board for Nursing, Midwifery and Health Visiting and is being undertaken by Sue Davies, Lorraine Ellis and Sara Laker of the School of Nursing and Midwifery, Dr Charlie Brooker of the Sheffield Centre for Health and Related Research, Professors Ian Philp and Tony Warnes of the Department of Health Care for Elderly People and Professor Alan Walker of the Department of Sociological Studies, all at the University of Sheffield.

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Tel. (0114) 2755411 Fax. (0114) 275 9933

☐☐☐☐

1. Course Title: ....

2. How many places are there on each intake? _____

3. How many intakes are there each year? *(If your centre is multi-sited please give the number of intakes for the centre as a whole).* _____

4. How many nurse teachers (approx.) contribute to the taught programme? _____

5. How many nurses in practice (approx.) contribute to the taught programme? _____
(Please give examples)
....
....
....

6. How many non-nurses contribute to the taught programme? (e.g. physiotherapists, medical staff, or non-clinical lecturers)? _____
(Please give examples)
....
....
....

7. Which of the following teaching methods are used within the course and what is the average group size for each method?

	Please tick all that apply	*Average group size*
Lectures	☐	_____
Seminars	☐	_____
Self-directed learning	☐	_____
Experiential learning	☐	_____
Student-led presentations	☐	_____

8. In which year was the course last validated by the English National Board?

19.............

9. Have there been any significant changes to the curriculum since validation?

Yes ☐ No ☐

If yes, please describe these changes:

....

....

....

....

10. What changes (if any) would you like to make to the way that the course is delivered?

(If none please state none)

....

....

....

11. Are there any opportunities for students to negotiate course content?

Yes ☐ No☐

If yes, please give examples:

....

....

....

....

Any other comments: ....

....

....

....

12. Are students able to negotiate course work such as essay titles? Yes ☐ No ☐

If yes, please give examples:

....

....

....

....

Any other comments: ....

....

....

13. Please indicate where you would recommend increases, decreases or unchanged emphasis on the following subject elements of the course.

Course Subject	***Please circle the response that most closely matches your view***				
Law	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Social Sciences	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Biological Sciences	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Ethics	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Nursing Theory	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Inter-personal skills	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Research	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Professional issues	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Teaching	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Health Promotion	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*
Other *(please specify)*	*N/A*	*Exclude*	*Less emphasis*	*About the same*	*More Emphasis*

14. Please describe any strategies within the course designed to help students make links between theory and practice

....

....

....

....

15. Please describe any strategies within the course for **assessing** students' ability to make links between theory and practice?

....

....

....

....

16. In your experience as Programme Manager please rank from 1 - 6 *(1= most important, 6= less important)* the priority allocated to the following objectives:

Objective	**Priority**
develop an understanding of the physiological, psychological and sociological effects of the ageing process	
promote the adoption of a holistic approach to the care of elderly people incorporating their individual physical and psychosocial needs, beliefs and value systems	
develop the ability to identify and implement appropriate action which will enable the elderly person to return to and maintain self-help skills and independence	
discuss the relevance of a multi-agency approach to the care of elderly people and understand the role of the nurse within the team	
develop awareness of the value of health promotion and primary health care provision for elderly people	
develop an awareness of mental health legislation as it relates to the elderly mentally ill person	

17. Does your course have a social policy content? Yes ☐ No ☐

If yes, is there specific reference to social policy and the older person?

Yes ☐ No ☐

Please describe this content:

....

....

....

....

18. Are students given a copy of the UKCC Code of Conduct? Yes ☐ No ☐

Are there any sessions in which students can discuss the impact of the Code on their practice?

Yes ☐ No ☐

Please give an example:

....

....

....

....

19. Are students made aware of the content of the Patients' Charter? Yes ☐ No ☐

Are there any sessions in which students can discuss the impact of The Charter on their practice?

Yes ☐ No ☐

Please give an example: .

....

....

....

....

20. How do the following topics feature in your programme?

Topic	*Please ring the answer closest to your view*			
The promotion of patient/ client choice	*Not at all*	*Mentioned*	*Focus topic*	*Thoroughly discussed or project*
The special needs of elderly people	*Not at all*	*Mentioned*	*Focus topic*	*Thoroughly discussed or project*
Patient/client participation in care	*Not at all*	*Mentioned*	*Focus topic*	*Thoroughly discussed or project*
Individualised needs assessment	*Not at all*	*Mentioned*	*Focus topic*	*Thoroughly discussed or project*
Promoting independence & self care for patients/clients	*Not at all*	*Mentioned*	*Focus topic*	*Thoroughly discussed or project*
Managing risk in relation to patient/client safety	*Not at all*	*Mentioned*	*Focus topic*	*Thoroughly discussed or project*

21. Please identify any modules/units within the course programme where the promotion of patient/client autonomy and/or independence features as a topic:

....

....

....

....

22. Please give an example of the way in which the course deals (if at all) with factors special to the older frail patient:

....

....

....

....

23. In your opinion, does the course programme enable nurses to promote the autonomy and independence of older patients/clients? Yes ☐ No ☐

If yes, please describe ways in which this happens:

....

....

....

Any other comments:

....

....

24. In relation to meeting the needs of older people, please comment upon any ways in which the course might complement or build upon other programmes of study:

....

....

....

....

25. Which of the following methods are used to evaluate the course:

Method	***Please ring the appropriate answer***			
Self-completion questionnaire to course members	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*
Self-completion questionnaire to teachers	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*
Discussion (students and teachers)	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*
Discussion (students and practitioners)	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*
Staff/Student Course Committee	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*
Course Curriculum Management Team	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*
Other *(Please specify)*	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*
Other *(Please specify)*	*More than once for each intake*	*Once for each intake*	*For some intakes*	*Never*

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26. Are students followed up once they have completed the course?

All ☐ Some ☐ None ☐

27. **If yes,** how often are they followed up?

More than twice ☐ Twice ☐ Once ☐

Please describe the nature of any follow-up:

....

....

....

....

28. In what ways are practitioners involved in developing the course curriculum? *(Please ring those which apply)*

As members of course team	*By commenting on proposals*	*Not at all*

Please comment:

....

....

....

....

29. To what extent are service users / patients involved in developing the course curriculum? *(Please ring those which apply)*

As members of course team	*By commenting on proposals*	*Not at all*

Please comment:

....

....

....

....

30. Is the course based on a particular curriculum model or models?

Yes ☐ No ☐

If yes, please identify the model(s)

……………………………………………………………………………………………………

Any other comments:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

31. Do you find the curriculum model useful in helping to address the issues of patient/client autonomy and independence?

Yes ☐ No ☐ Not applicable ☐

Please comment:

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

32. Are any key texts/references used for the course elements relating to promotion of patient/client autonomy and independence?

Yes ☐ No ☐

If yes, please list (or attach the reading list)

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

Is there is anything else about the course which would help us to understand how students are enabled to meet the needs of older people? Additional comments would be most helpful:

....

....

....

....

....

....

....

....

Please do not hesitate to send us any course brochures, evaluation forms or other materials which would help us gain a more complete understanding of the course.

Finally, if we needed to check any detail and you would be willing to give us information over the phone, please enter your name and telephone number:

....

We will be following up this impersonal postal survey with a small number of face-to-face interviews. Would you be willing to be selected for interview?

Yes ☐ No ☐

These would be arranged in advance at a time convenient to you.

Many thanks for all your time and patience. The information you have given will be of great help, indeed your co-operation is vital to the study's success.

APPENDIX III

Curriculum Document Checklist (Phase II)

Curriculum Checklist

Individualism is a recurring theme within the documentation, highlighted in the philosophy, reflected in the curriculum model , indicated by teaching and assessment strategies, course content, delivery and learning outcomes.

Course Philosophy

Nursing	Individuals seen as unique human beings entitled to make decisions and choices. Individuals consulted over care Self care emphasised Total care needs or holism emphasised - social, psychological, physical and spiritual Nurses function in case of self care deficit - educator and supporter until self care restored
Education	Individuals encouraged to take responsibility for own learning - supported in this Self development emphasised Reference to androgogy and/or Knowles, Rogers
College	Reference to college philosophy Promotion of autonomous teachers TQM

Reference to National Regional and Local Policies / Initiatives emphasising Individual Rights

Patients Charter
Code of Conduct
Scope of Practice
Relevance to the needs of the public as the ultimate consumer demonstrated

Curriculum Model / Framework

Curriculum Model - Equal weighting given to the needs of the learner, teacher, curriculum and statutory requirements of the English National Board?

Curriculum Model flexible enough to meet individuals needs and aspirations whilst meeting the course learning outcomes, indicative content and statutory requirements?

Managing change in clinical practice emphasised

Relationship between the curriculum model and the course philosophy demonstrated

Course Content

Teaching and Assessment Strategies / Learning Journal, Essays - Topics selected by course leader and / or course member
Lectures / Discussions
Teacher - student ratio
Indicative content
Indicative reading
Suggested / recommended reading

Learning Outcomes

Acts as an autonomous practitioner within the multidisciplinary team

Promotes independence in life and death through choice

Provides information on the use of alternative / complementary medicines

Promotes access to agencies / resources in the community

Takes responsibility for own learning

Evaluates care

Undertakes a comprehensive needs assessment

Plans how those needs might be met

Reformulates the plan of care in light of the evaluation

Is aware of the alternative resources

Recognises situations detrimental to the health and wellbeing of the individual *

Develop an ability to continue learning following the course

Practice with regard to social, political and professional issues

To advise individuals on the promotion of health and the prevention of illness

Congruence between safety and the promotion of autonomy and independence

Evaluation Strategies

Frequency and Nature
Questionnaire
Questionnaire preamble
Evaluations used to inform future course developments
Evaluations in the form of course member presentations
Clinical nurse manager present

Curriculum Vitae of Course Leader / Significant others

Publications in the specialism
Years experience in the specialism
Qualifications

Match between the philosophy , course content , learning outcomes, teaching / learning and assessment strategies.

APPENDIX IV

Questionnaire to Continuing Care Facilities (Phase II)

Questionnaire to Continuing Care Facilities

This questionnaire should be completed by the most senior nurse within the facility who has direct responsibility for patient/resident care. This will normally be the ward or nursing home manager, but in some cases the manager may not be a qualified nurse. In such cases, the questionnaire should be completed by the most senior qualified nurse within the establishment.

The questionnaire is divided into three sections:

Section 1	Information about the person completing the questionnaire
Section 2	Information about other nursing staff employed within the ward/nursing home
Section 3	Information about the patients/residents and normal practices within the ward/nursing home

Please answer all questions and return the questionnaire in the pre-paid envelope. Responses will be treated in strictest confidence.

For further information contact:
Sue Davies (Project Director)
Lorraine Ellis (Research Associate)
Sara Laker (Research Assistant)

Postgraduate and Research Centre, 8 Brunswick Street, Sheffield S10 2FN
Tel No. (0144) 276 3125 (direct line)

Section 1

1) What is your current job title ____________________

Do you own the establishment in which you work? YES NO
(please circle appropriate response)

2) How long have you worked:

a) in this post? months __________

b) in this establishment? months __________

3) Which of the following qualifications do you have:
(Please tick all that apply and give the year of completion)

		Year
Registered General Nurse/State Registered Nurse	☐	__________
Enrolled Nurse	☐	__________
Registered Mental Nurse	☐	__________
Degree in Nursing	☐	__________
Other degree please specify __________ __________	☐	__________
ENB 941 (Nursing Elderly People)	☐	__________
ENB 298 (Nursing Elderly People)	☐	__________
Community nursing qualification e.g Health Visiting/District Nursing	☐	__________

Other qualifications
(Please Specify) ____________________

____

4) **Are you currently undertaking any educational programmes related to your work?**

YES ☐ NO ☐

If yes, please list education programmes together with expected completion date:

____________________ ____________

____________________ ____________

5) What is your age? ____________________

Section 2

6) How may nursing staff are employed in your ward/nursing home?

	Total employed	*No. of staff who work part-time*
Number of first level qualified nurses (Registered General Nurse, Registered Mental Nurse)	________	________
Number of second level qualified nurses (Enrolled Nurse)	________	________
Number of unqualified nurses (i.e. those with responsibility for direct care of patients/residents e.g. health care assistants, nursing auxiliaries)	________	________

7) Which of the following qualifications do your staff members have?
(Please give the number of staff with each qualification)

Registered General Nurse/State Registered Nurse no. = ____________

Enrolled Nurse no. = ____________

Registered Mental Nurse no. = ____________

Degree in Nursing no. = ____________

Other degree no. = ____________

ENB 941 (Nursing Elderly People) no. = ____________

ENB 298 (Nursing Elderly People) no. = ____________

Community nursing qualification no. = ____________

e.g. Health Visiting/District Nursing

Other qualifications
(Please Specify) ____

____

8) How many of your qualified staff are currently undertaking educational programmes.

Please specify course and indicate number of staff

Course	*No.of Staff*
____________________	____________
____________________	____________
____________________	____________

9) **How many of your unqualified staff hold National Vocational Qualifications (NVQs)**
If none please state none.

Level 1 __________ Level 2 __________ Level 3 __________

10) How many of your unqualified staff are currently undertaking National Vocational Qualifications (NVQs)

Level 1 __________ Level 2 __________ Level 3 __________

11) Does your ward/home provide placements for nursing students?

YES ☐ NO ☐

12) What type and frequency of contact do you have with local Colleges of Nursing?

____

____

____

Section 3

13) Which of the following best describes your facility?

Voluntary Sector Nursing Home ☐

NHS Nursing Home ☐

Private Nursing Home ☐

14) How many places/beds does your ward/nursing home have? __________

15) How many places/beds are occupied at the present time? __________

16) What number of beds are designated for residents with special needs?
(e.g. EMI, young disabled, terminal care etc.)

Type	*No.*

17a) Approximately what number of your residents/patients require each of the levels of nursing care described below?

Each patient/resident should be placed in one category only.	***No.***
24 hour constant supervision and assistance with personal care	
Frequent assistance and supervision but not constant care by day and night (at least every 2 hours)	
Occasional care and assistance.	

b) Approximately what number of your residents/patients are regularly disorientated to time and place? __________

Please answer each of the following questions in relation to your ward/home.

		YES	*NO*	*Comment*
18)	Can residents use their bedrooms whenever they want?	☐	☐	
19)	If assisted, can residents come and go outside the home?	☐	☐	
20)	Are there separate toilets for men and women?	☐	☐	
21)	Are residents taught new skills?	☐	☐	
22)	Do residents go to bed when they wish?	☐	☐	
23)	Are there both smoking and smoke-free rooms?	☐	☐	
24)	Are there facilities in the residents' bedrooms to lock away possessions?	☐	☐	
25)	Do residents have privacy when they wish?	☐	☐	
26)	Is there somewhere residents can make telephone calls in private?	☐	☐	
27)	Is there a lounge with no television?	☐	☐	
28)	Are bedside lights provided and can they be used by residents?	☐	☐	
29)	Do all bedrooms have electrical sockets that residents can use?	☐	☐	
30)	Is there a garden for residents to sit in?	☐	☐	
31)	Is it easy for mobile residents to get into the garden unaided?	☐	☐	
32)	Is there a visitors' room?	☐	☐	
33)	Are residents encouraged to maintain their self-care skills?	☐	☐	
34)	Do staff encourage residents to help themselves?	☐	☐	
35)	Are staff encouraged to sit and talk to residents as part of their job?	☐	☐	

Please add any other comments you would like to make below:

Thank you very much for your assistance in completing this questionnaire.

APPENDIX V

Additional tables (Phase II)

SURVEY OF CONTINUING CARE FACILITIES: ADDITIONAL TABLES

Table 5.15 *Characteristics of respondents in relation to time in post, time in establishment and age by job title*

		Time in post (months)		Time in establishment (months)		Age (years)	
Title	**n**	**Mean**	**Range**	**Mean**	**Range**	**Mean**	**Range**
Matron	401	45.4	1-365	54.3	1-384	44.7	24-74
Sister	14	51.7	6-140	61.8	3-174	43.5	27-60
Primary nurse	12	28.1	<1-80	43.3	2-132	41.2	23-62
Manager	141	42.2	1-288	50.8	1-300	43.8	23-63
Dual-role matron	34	94.4	2-310	88.9	2-310	47.7	32-66
Proprietor	3	151.7	86-208	151.7	86-204	54.7	47-64
Other	49	52.2	1-384	50.6	1-204	46.7	26-62

Table 5.16 *Beds and occupancy by type of facility.*

		Number of places/beds			Places/beds occupied		
Type of home	**Cases**	**Mean**	**95% CI**	**Range**	**Mean**	**95% CI**	**Range**
Voluntary sector	31	33.7	(28.1, 9.3)	10-95	32.2	(27.1, 37.3)	10-87
Private nursing home	615	39.0	(37,0, 41.0)	5-424	34.7	(32.8, 36.6)	5-390
Private, with NHS beds	11	36.0	(29.7, 2.3)	18-54	32.3	(25.4, 39.2)	17-54

Table 5.17 *Numbers of patients/residents requiring 24 hour supervision and assistance, or frequent assistance and supervision.*

	24 hour constant supervision			**Freq assistance and supervision**		
Type of home	**Mean**	**95% CI**	**Range**	**Mean**	**95% CI**	**Range**
Voluntary sector	14.4	(9.61, 9.2)	0-60	9.4	(5.9, 12.9)	0-36
Private nursing home	18.2	(16.8, 9.6)	0-150	11.9	(10.3, 13.5)	0-346
Private, with NHS beds	12.4	(5.1, 19.7)	0-38	10.1	(6.9, 13.4)	2-20

Table 5.18 *Numbers of patients/residents requiring occasional care and assistance, or are regularly disorientated to time and place.*

	Occasional care and assistance			**Regularly disorientated**		
Type of home	**Mean**	**95% CI**	**Range**	**Mean**	**95% CI**	**Range**
Voluntary sector	7.1	(4.1, 10.1)	0-29	12.9	(8.6, 17.2)	0-58
Private nursing home	3.9	(3.3, 4.5)	0-115	13.6	(12.5, 4.7)	0-105
Private, with NHS beds	10.0	(3.1, 16.9)	0-30	10.4	(4.9, 15.9)	0-30

APPENDIX VI

Interviews with older people carried out to inform the development of research tools (Phase III)

Appendix VI

INTERVIEWS WITH OLDER PEOPLE - DEVELOPMENT OF THE OBSERVATION TOOL AND QUESTIONNAIRE

In order to inform the development of the instruments for Phase III of the a small number of older people were interviewed about their recent experiences of nursing care.

The project team contacted a local branch of Age Concern to gain access to older people who had recent experience of nursing care, either as an in-patient or in the community, and who might consent to being interviewed. Six people were approached by Age Concern and two consented to take part. The final sample of five included three older people known to the project team.

The interviews were semi-structured using a flexible schedule. The questions were designed around some of the themes identified in the literature as being components of autonomy and independence. All the interviews were carried out by the same member of the research team.

The ages of the interviewees ranged from 72 - 93 years. They described themselves as white. All had been cared for in hospital during an acute phase of physical illness and two had been cared for by a district nurse on different occasions. The experiences described to the researcher related to their hospital admissions.

Treatment as an older person in hospital

All respondents agreed that in their experience older people were not treated differently to other people whilst in hospital. They also agreed that older people should not be treated differently; however it was recognised that older people may not be able to carry out certain activities.

> *" No, I don't think you should treat them differently but obviously there are some things that you can't look at an older person and say that'll do for him because they may not be able to do these things.."*
>
> *" Sometimes personally the anaesthetic takes a lot out of me and I cannot sit out and eat, I just cannot cope with the exhaustion of sitting out afterwards and digesting my food my heart is pounding and I can't cope I need to be back on the bed.."*
>
> *" When I'm saying that all I'm saying really is that unless you show signs of disablement and then there is a great display of nurses helping and enthusiasm to get extra pillows and things like that, but then in my case I would have thought that they treat me ordinarily which is a complement, you know.."*

Impressions of nursing care

Several aspects of nursing were particularly appreciated:

> *" I found that they were considerate to show you where things were and introduce you...."*

> *" I like the modern way of talking to you, you're no longer the old number in the bed....They tell you everything and even discuss the anaesthetic. I think that's wonderful."*

> *" I think that the hospital staff do make allowances for older people who aren't as nimble as they used to be..."*

However, all the participants could identify care that was not as they thought it should be.

> *" Well I think the rushing is a bit much ..... especially when after an eye op I had to get out and sit to the table and eat that was the last straw really. I wasn't steady, I think that I have been fortunate to have been near the toilet I have seen others staggering down the ward and I've really thought that they were going to collapse that's worrying."*

> *"I would have liked to have been able to clean my teeth at night there was no beaker at all for cleaning out teeth we had to use out drinking beaker ... "*

> *" The last time I was in .... my daughter was told we can't get your father to shave so to which she said no its a beard he wears, she said oh we hadn't noticed that, so they were trying shave me and I'm saying no, no, ..."*

Some of these issues were not directly to do with nursing care.

> *" I was disappointed about the toilet because you are given .... a container of fluid to take to empty your bowels and the people who are employed to clean the toilet really didn't know that the toilet was in intense use and they had dismissive thing "my god what do you men do in here!"*

> *" And there's the little things like squeaky trolleys that just need an oil can."*

Information and Decision Making

There was a mixed response regarding the information provided during the participants' admission to hospital. Two of the respondents were satisfied with the information that both they and their relatives/friends received.

> *" Oh, very good as a matter of fact there's a nurse .... and her speciality is telling you all about it when you've had a heart attack, the heart nurse I think she's known as .... she was very good I must say that and I've got the booklet still telling me all about myself..."*

> *" Oh yes if they had needed it they could have had it they know that all was going very well when they phoned in they got a reply at once you know."*   *(re information given to relatives/friends)*

However, problems with information giving were also identified. One participant described an event when the anaesthetist came to ask which pain control he and another patient would like after surgery the choice being between a *'motor driven timed injection'* or *patient controlled pump - 'a hand control thumb press thing.'*

> *".... the choice seemed not to be an informed choice you fell dithery about which to choose .... we found ourselves having this buzzing mechanism on a tripod .... I would think of all the things that was the thing that I still feel inadequately informed about .... with this tripod walking thing it was added to all the ups and downs so it was a bit of a job going to the loo."*

Another participant described an event when she was discharged from hospital where she felt both herself and family were given inadequate and conflicting information.

> *"I think we were lead to believe that we could do a lot of things too early and that was a set back because you are out the hospital so early now you're not really on you're feet properly."*

She then gave an example:

> *".... it was long after I complained, months afterwards that I didn't seem to get well that I was told things like " well sitting in a car is not much good to you yet", "you shouldn't have done a lot of bending about" all this sort of thing and it was ridiculous. I mean we'd been told that I could travel and that was wrong, it was awful afterwards I was bending about picking up things off the floor ...."*

Most participants felt that they did have a degree of involvement in decision making in their day to day care.

> *"I can't think of a region where it could of been altered in communication or whatever."*

> *"'When I felt very ill one day I got back on the bed that was questioned but when I explained no one argued."*

However there was also a suggestion that behaviour was sometimes dictated by complying with nurses or trying to please them:

> *" I think I had choices I think when you were feeling as well as I was I did whatever seemed simplest for the nurses.. "*

> *" .... bathing I never argued about it."*

One participant in particular found it extremely traumatic to be *told what to do by young girls.* He recounted an incident where a physiotherapist had been trying to encourage him to walk whereas he felt that at his age (93) he should be making the decision for himself.

An interesting point was raised by one participant regarding the effect of agency nurses on involvement of the older person in decision making.

> *" There were moments when you felt that the changes of nurses .... agency nurses that didn't seem to be as familiar, obviously as familiar, with the routines of you own personal need. I mean they came and looked at the charts at your temperature and looked at your drug chart and walked round with the drug trolley and that was a bit disconcerting in a sense. Their attitude to you was not like that which had been consistent throughout."*

Maintaining independence and safety

All the participants were emphatic about maintaining their independence, however whilst in hospital some of the interviewees identified that the degree of independence was dependent on 'your condition' and that the decision of how independent they were should be theirs 'not until I feel secure'. The interviewees also demonstrated that they felt there were times when it would be all right for the nurses not to let them be independent.

> *" I think you need enough protection and I know quite a few people who have fallen."*

> *" Yes when I first started looking and not knowing how to disentangle myself with whatever it was that I was tangled up with I really you know did need a bit of assistance really...."*

One participant did not feel you could be independent in hospital at all.

> *" I don't think you can be independent in hospital you have to rely on everybody for everything don't you."*

Overall the interviewees did not feel that nurses were overprotective. In relation to older people having cotsides on their beds, the majority view was that it depended on the person's condition and that nurses would not put them on unless they were needed.

> *" I'm quite sure that if the doctor of the nurse came to me and said we're going to have to put cotsides up - why - to stop you falling out of bed - fine that's OK."*

In the case of confused older people being given medication to produce a sedative effect, participants generally felt that this was a difficult decision for nurses to make and that people would have to make their minds up individually for each situation.

> *" I do think you do have trust and its a decision making that is only for them."*

> *" I don't know it must be a great problem for nurses."*

There was concern expressed that medication should be given as a last resort and not given in any great quantity.

> *" Well not more than they needed I would say."*

The views and experiences of these older people can in no way be generalised. Certainly, it was not our intention to use this information in any way other than to gain some insight into older peoples' experiences of nursing care and to ascertain whether the dimensions of autonomy and independence identified on the basis of the literature review resonated with older people themselves.

The interviewer found a degree of the 'halo' effect in that participants were reluctant to criticise nurses' care, or if they did, they would offer an excuse, usually that the nurse was very busy or overworked. This led to obvious examples of what Waterworth and Luker (1990) describe as patients 'toeing the line'.

> *" I think I had choices I think when you were feeling as well as I was I did whatever seemed simplest for the nurses.. "*

The interviews confirmed that for these older people, individualised assessment and care-giving were very important. Participants expected to be involved in decisions about their activities of daily living and examples of care that was *'not as it should have been'* reflect this. This finding supports Biley's (1992) study where patients appeared not to question technical care but preferred to make decisions regarding their activities of daily living. Participants also felt that they should be the ones to decide when they felt ready to be independent in a certain activity and when they required help. However in relation to issues of involvement and participation, as identified by Biley (1992), there were also suggestions of 'nurse/doctor knows best'.

> *" I like to think that even though I'm getting old and forgetful I should have the good sense to realise that no matter what they tell you that its for your own good. "*

As highlighted in the literature review, this could be due to reasons of social desirability and fear of reprisals (Breemhaar et al 1990).

Communication in the form of information, involvement and social interaction were important components of nursing care for these older people. One participant identified a lack in communication that could be interpreted as reciprocity (Marck 1990): she wished that the nurses had more time *'just to have a cheerful word'* and continued *'I don't mean long conversations but you know just a hello how are you feeling and so on.'*

In summary, the views and experiences described in these interviews suggest that the dimensions of interest forming the basis of the instrumentation for the study are of importance to older people. One participant offered the following advice for nurses:

> *" .... I think you just, you can't put yourself into the place of an old person I couldn't have done. Just remember that the more helpless you are either through sickness or age the more vulnerable you are to the way your are treated. I know you can get cantankerous old people that hit out at you that must be trying but in the main I would say just be as kind as you can remembering that you don't like being hurt or bossed, yes just kindly as you have time to be. "*

APPENDIX VII

Questionnaire for nurses working with older people (Phase III)

University of Sheffield

EVALUATION OF PRE-AND POST-REGISTRATION EDUCATION PROGRAMMES

A QUESTIONNAIRE FOR NURSES WORKING WITH OLDER PEOPLE

Please complete the questions as best you can and without first discussing your responses with other people. The information is collected exclusively for research purposes: nothing will be passed to any individual or body. It will be scrupulously protected as strictly confidential: no reference to identifiable individuals or organisations will be made.

This study is supported by the English National Board for Nursing, Midwifery and Health Visiting and is being undertaken by Sue Davies, Lorraine Ellis and Sara Laker of the School of Nursing and Midwifery, Professor Charlie Brooker of the Sheffield Centre for Health and Related Research, Professors Ian Philp and Tony Warnes of the Department of Health Care for Elderly People and Professor Alan Walker of the Department of Sociological Studies, all at the University of Sheffield.

Enquiries about this project may be directed to Sue Davies, Postgraduate and Research Centre, School of Nursing and Midwifery, University of Sheffield, 8 Brunswick Street, Sheffield S10 2FN.
Tel. (0114) 2755411   Fax. (0114) 275 9933

General Information

☐☐☐☐☐☐

1. Which of the following best describes your current area of practice?
(Please tick one response only)

Acute surgery ☐
Acute medicine ☐
Acute psychiatry ☐
Rehabilitation ☐
Continuing care (NHS) elderly ☐
Other *(Please specify)* ☐

Community (district nursing) ☐
Private nursing home ☐
Community (health visiting) ☐

....

2. What is your current job title?

....

3. and grade? (*please ring*)

C D E F G H I Other *(please specify)* ....

4. Which of the following qualifications do you have?

(please tick all that apply and give the year of completion)

		Year
RGN/Diploma of Higher Education in Nursing (Project 2000)	☐	....
Registered General Nurse/State Registered Nurse (Pre Project 2000)	☐	....
Enrolled Nurse	☐	....
Registered Mental Nurse	☐	....
Registered Mental Handicap/Learning Disabilities Nurse	☐	....
Other UKCC registered qualification/s (*please specify*)		
....	☐	....
....	☐	....
Degree in Nursing	☐	....
Other degree (*please specify subject)*	☐	....
....		
Other qualifications including clinical courses, framework modules, NVQs *(Please specify)*	☐	....
....		....

5. **How long in total have you been working with older people?** Years......... Months...........

6. **Did you choose to work with older people in your current job?** *(Please tick one response)*

Had no real choice, it was where they had a trained staff vacancy	☐
Not really, it just happened that way	☐
Yes definitely, I wanted to work with older people	☐
Other reasons *(please specify)*	☐

....

....

7. **Do you currently care for older people who are:**

(please tick as appropriate) Female ☐ Male ☐ Both ☐

8. **Please indicate your gender:** Female ☐ Male ☐

9. **Please state your age** *(years)* ....

Skills development

10. **In your opinion, did your pre registration nurse education prepare you to care effectively for older patients/clients?**

Yes, to a great extent ☐ Yes, to some extent ☐ Not at all ☐

11. **In your view, do qualified nurses require special post-basic training to care effectively for older patients/clients?**

Yes, this should be mandatory ☐ Yes this is desirable ☐ No, adequately covered in pre-reg ☐

12. **Please list those aspects of your own skills and/or knowledge which require further development in order for you to care for older people as effectively as possible?**

13. **In your present job situation, is good use being made of your skills?**
(Please ring appropriate response)

Skill	***Utilisation in current post***				
Rehabilitation	*Very little use*	*Little use*	*Some use*	*Good use*	*Very good use*
Technical nursing	*Very little use*	*Little use*	*Some use*	*Good use*	*Very good use*
Management	*Very little use*	*Little use*	*Some use*	*Good use*	*Very good use*
Teaching	*Very little use*	*Little use*	*Some use*	*Good use*	*Very good use*
Communication	*Very little use*	*Little use*	*Some use*	*Good use*	*Very good use*
Research application	*Very little use*	*Little use*	*Some use*	*Good use*	*Very good use*

14. **Which of the following activities takes up most of your time during a normal working day?**

Please rank the activities listed below from 1 to 6, 1 for the activity that takes up most time and 6 for that which takes up least time.

	Ranking (time taken)
Helping patients/clients to move around and become more mobile	....
Encouraging patients/clients to do things for themselves	....
Keeping patients clean and comfortable	....
Communicating with patients/clients	....
Completing paperwork/documentation	....
Stimulating patients to take an interest in their surroundings and themselves	....

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15. **The statements below have been made about the ways in which nursing care for older people might be organised.** Please read each statement and indicate whether you feel it is desirable and possible for care to be organised in this way. *Please give your response by placing a tick in the appropriate column.*

I believe that organising care in this way is

	Desirable and always possible	Desirable and sometimes possible	Desirable but rarely possible	Not desirable	Not applicable to my current practice *(Please comment)*
A full assessment is made of patients prior to giving care					
A written nursing history is taken using a specific form					
Written care plans are produced which incorporate patients' needs/problems					
Health promotion forms an important goal of care					
The patient's/client's problems/needs are prioritised					
Care plans are updated regularly as a basis for care giving					
Promoting patient autonomy is an important goal of care					
Written patient goals are used as a basis for evaluating care					
Patient assessment and care planning is based upon an identified model of nursing					
Patient care is organised using a system of primary nursing					
Talking to patients as individuals is an important priority of care					

Questions 16 - 24 relate to what your current nursing practice, but some questions may not be applicable to your current practice setting. If this is the case, please add a comment. *Please answer each question as honestly as possible by ringing the appropriate response, adding comments if you wish:*

16. Do you offer patients/clients a choice over the time during the day when they have a wash/bath/shower?

NEVER SOMETIMES FREQUENTLY ALWAYS

Comment:

17. Do you allow patients/clients to determine when their own clothes are changed?

ALWAYS FREQUENTLY SOMETIMES NEVER

Comment:

18. Before you talk to a relative about a patient, do you ask the patient's permission?

ALWAYS FREQUENTLY SOMETIMES NEVER

Comment:

19. Do you encourage male patients/clients to shave themselves?

ALWAYS FREQUENTLY SOMETIMES NEVER

Comment:

20. Do you encourage patients/clients to plan for the future?

NEVER SOMETIMES FREQUENTLY ALWAYS

Comment:

21. During conversation with patients/clients are there times when you share aspects of your life outside work?

OFTEN **SOMETIMES** **RARELY** **NEVER**

Comment:

22. Within your practice, do opportunities arise to educate elderly patients/clients about their health?

NEVER **RARELY** **SOMETIMES** **OFTEN**

Comment:

23. Do you encourage elderly patients/clients to evaluate their progress?

OFTEN **SOMETIMES** **RARELY** **NEVER**

Comment:

24. If an older person with whom you are working makes you feel good, do you tell them?

OFTEN **SOMETIMES** **RARELY** **NEVER**

Comment:

25. **Please list as many activities as you can think of for protecting an older person's privacy in your own practice setting:**

26. The following questions relate to your views about planning care for patients/clients. *Please indicate the extent to which you agree or disagree with the following statements by ringing the most appropriate response:*

i) In order for patients/clients to participate in decisions about their care, it is essential that they have the ability to concentrate and remember what they are told	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
ii) Patients and clients should be allowed to choose ways of behaving/types of care that are not necessarily in line with the views of the health care team	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
iii) I prefer to get to know a person gradually because I believe their wishes, problems and needs will become apparent as they come to trust and confide in me.	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
iv) Patient participation in planning nursing care is only possible if patients/clients have some insight into what is wrong with them	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
v) Ensuring that patients/clients comply with medically prescribed care is one of the most important aspects of my job	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
vi) Participation can take place at many different levels from what to wear, to planning long-term goals of care	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
vii) An initial assessment of a person's needs ensures that their wishes are identified.	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
viii) I think it's right that people should be protected in certain circumstances from information about their condition	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
ix) Generally, I understand a person's needs at first assessment	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
x) Involving relatives in care planning often confuses things	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*

27. Please indicate the frequency with which each of the following statements applies to your current practice by placing a tick in the appropriate column:
(please add a comment if you wish)

	All/most of time	**Some-times**	**Rarely or never**	***Comment***
I ensure that patients/clients attend all meetings at which they are discussed				
Patients/clients views are taken into account in decision making				
I prefer to address patients/clients by their first name				
I generally ask the person what they understand and how they feel before commencing a procedure.				
I try to ensure that the nurse who knows the patient/client best is present for major procedures or to give detailed information to the patient				

Questions 28 and 29: Please complete the following sentences in relation to your own practice:

28. The most effective way in which older peoples' autonomy can be promoted in my own area of work is:

29. The biggest problem in promoting patient/client autonomy in my own area of work is:

Questions 30 - 32 set out statements which might be made by patients/clients when talking to you. For each statement, five possible replies are given. Please choose the statement which would be the most helpful reply and circle the preceding letter. *Please choose only one reply for each statement.*

30. Patient: ***"I know smoking is bad for me, but I don't seem to be able to stop. Anyway, I don't see that it's any of your business. It's my body that I'm harming, not anyone else's".***

(a) "I am concerned that if you go on smoking, your health will suffer. You seem to want to stop, but you're not sure how to go about it. Perhaps I can help you? "

(b) "You should have more respect for your body. Anyone can stop smoking if they really want to. You're just not trying hard enough".

(c) "I get the feeling that you're worried about your smoking, and that you wish you could stop. I share your concern, and I feel that you've got the strength to give up smoking. I would like to help you try"

(d) "You're right that its your body that's being harmed, but that doesn't stop me from being concerned for you. I wonder if there is anything I can do to help you stop"

(e) "That's not entirely true. Other people breathe in your smoke as well. Perhaps you should think more about them"

31. Patient: ***"I'm in dreadful pain and I know I've only got a few days left to live. If you had any feelings for me, you'd give me something to put me out of my misery"***

(a) "What makes you think you're going to die? You might have years ahead of you"

(b) "It distresses me to think of you in pain like this, and I feel frustrated at being unable to do what you are asking. I believe that you have the right to decide your own fate, and I feel annoyed that the law won't allow me to help you in this way"

(c) "I am very upset that you are suffering so much, and I wish there was something I could do. I am very confused about the whole issue of euthanasia, but I can see the sense in what you are saying"

(d) "You know I can't do that. As a nurse I have to keep you alive for as long as possible"

(e) "You seem to be suggesting that I have no feelings for you. That just isn't true. I'd like to do something to help, but that's just not possible"

32. Patient: ***"These pills are doing me no good at all. You might as well know that for the past three days I have only been pretending to swallow them"***

(a) "You seem to be worried that these pills are not working, and may even be doing you some harm. It's your decision whether or not to take them, but it might be helpful to discuss your anxieties about them and think about some other options"

(b) "You don't think these pills are any good. Would you like to talk to the doctor about them?"

(c) "How will you ever get better if you don't follow medical advice? These pills are the best medication for your particular problem. I shall have to tell the doctor that you haven't been taking them"

(d) "That's a really stupid thing to do. When the doctor prescribed those pills, he didn't mean for you to throw them away. Don't you want to get better?"

(e) "You are obviously concerned about these pills. Perhaps we could talk about why you feel that way, and maybe get them changed for something different"

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Questions 33 - 37 are about approaches to assessing risk and the maintenance of patient/client safety.

33. **In your own experience of nursing older people can you recall situations when the need to promote patient independence and choice has conflicted with the need to maintain patient safety?**

Yes, many times ☐ Yes, a few times ☐ No, never ☐

If yes, please describe an example:

34. **Please list the criteria which you use to decide that the risk outweighs a patient's rights to make their own decisions:**

35. **Which of the following approaches do you consider acceptable to minimise the risk of accidents?** *(Please ring the appropriate response for each method)*

a) Cotsides/bedrails	*yes in most circumstances*	*yes in some circumstances*	*hardly ever*	*never*
b) Arranging furniture to impede movement	*yes in most circumstances*	*yes in some circumstances*	*hardly ever*	*never*
c) Use of sedative drugs	*yes in most circumstances*	*yes in some circumstances*	*hardly ever*	*never*
d) Verbal commands	*yes in most circumstances*	*yes in some circumstances*	*hardly ever*	*never*
e) Dissuasion	*yes in most circumstances*	*yes in some circumstances*	*hardly ever*	*never*

36a) **When a patient/client insists on walking unaided but you know they are likely to fall, what do you say to them?**

36b) When an older person refuses help or even to use a napkin/bib when eating, what do you say to them?

36c) When a confused patient/client wanders and attempts to leave the ward/home what do you do?

37. For very frail patients, how do you see the relationship between their personhood and autonomy and their safety and medical care? *(Tick more than one box if you wish)*

Safety and medical care considerations overwhelmingly dominate ☐

The promotion of the patient's autonomy has to come second ☐

The promotion of the patient's autonomy can be pursued at quiet times of the day ☐

It is always possible to respect a patient's individuality and personhood even when counter-manding their wishes for clinical reasons ☐

It is appropriate to take risks with the patient's safety in the interests of promoting patient autonomy ☐

Thank you for your help in completing this questionnaire. The information you have given will be treated in strictest confidence.

Please return the completed questionnaire in the addressed envelope by
to:

Research Team (English National Board Project)
Postgraduate and Research Centre
8 Brunswick Street
Sheffield S10 2FN

APPENDIX VIII

Observation schedule and criteria for use (Phase III)

UNIVERSITY OF SHEFFIELD: EVALUATION OF NURSE EDUCATION STUDY

Nurse **Setting** **Date** **Start** **Finish**

Care setting - Contextual information

Number of patients

System of Nursing

No and level of staff on duty

Is the nurse in charge or not

General lay out of ward - e.g.: nightingale / bays or description of area covered (community)

Description of patients in nurse's care (age, diagnosis, mental state, gender) - **see list overleaf**

Type of patients in the nurses' care - conditions

Length of hospital stay (where appropriate) or average time on caseload (community)

Evidence of patient having a named nurse

Information about the setting-is it readily available to the patient

Patients charter - evidence of implementation

Information about the patients condition, health education, generally (availability)

Items that show individualised care of patients

Setting-acute ward rehab, community

UNIVERSITY OF SHEFFIELD: EVALUATION OF NURSE EDUCATION STUDY

Nurse **Setting** **Date** **Start** **Finish**

Activity codes: 1- Communication 2- Eliminating 3- Eating 4- Drinking 5- Personal hygiene/grooming 6- Dressing 7- Mobilising 8- Providing recreation 9- Technical care (identify in fieldnote)

Rating codes: 0- not at all 1- infrequently/misses most opportunities 2- intermittently/takes some opportunities 3- consistently/takes most-every opportunity

ACTIVITY:	choice	information/ explanation	eliciting feedback	reciprocity	privacy	participation	independence	safety	1 full 2 part	No. of carers
EVENT NO:										

Patient No

Time started event:

Time finished event:

ACTIVITY	choice	information/ explanation	eliciting feedback	reciprocity	privacy	participation	independence	safety	1 full 2 part	No. of carers
EVENT NO:										

Patient No

Time started event

Time finished event:

ACTIVITY	choice	information/ explanation	eliciting feedback	reciprocity	privacy	participation	independence	safety	1 full 2 part	No. of carers
EVENT NO:										

Patient No

Time started event

Time finished event:

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ENB FUNDED RESEARCH: EVALUATION OF PRE- AND POST-REGISTRATION EDUCATION FOR THE CARE OF OLDER PEOPLE

Phase III: Observation Schedule

Observation Protocol

- Observer spends approximately one hour familiarising self with care environment and patient/client needs

- Structured observation period continues for three hours.

- Each event is observed in it's entirety. Observer notes time event starts, then maintains continuous field notes describing as much of each event as possible including verbatim conversation as appropriate to the dimensions of interest.

- At the completion of each event, observer records time then completes the rating scale (0-3) for each dimension of interest. Some dimensions of interest may be not applicable for some stages of care.

- Observer then 'keys in' to next event and observes from beginning to end

Rating codes for observation schedule

Rating codes:

0- not at all
1- infrequently/misses most opportunities
2- intermittently/takes some opportunities
3- consistently/takes most-every opportunity

Criteria for each dimension of interest:

ACTIVITY	**Dimension of Interest: CHOICE**
GENERAL	**Offering the older person choice in relation to aspects of care delivery**
Technical care	Where, when, position
Drug administration	Offer of prn drugs? Affirmative and swift response to direct request for e.g. analgesia
Helping to mobilise/change position	Responding to older person's request for help to get in or out of bed Choice of aids/responding to older person's request for help Where, when and how. Affirmative and swift response to direct request
Evaluating/planning care	Offering the older person choice of whether to be involved in evaluation
Helping to meet hygiene needs	Affirmative response to older person's request for help with washing/bathing Accepting that patient/client does not want to wash/bathe Offering choice of washing by bed/helping to bathroom as appropriate
Elimination	Affirmative and swift response to older person's request for help. Offer choice of toilet/commode/bedpan as appropriate
Eating/drinking	Offering choice from available options Offering choice of place to eat

ACTIVITY	**Dimension of Interest: INFORMATION/EXPLANATION**
GENERAL	**Providing information or explanation about care given or about to be given** **Education**
Technical care	Informing older person of procedure to be undertaken Offering a commentary on nursing actions Education in relation to procedure
Drug administration	Information re need for/action/possible side effects of drugs Education
Helping to mobilise/change position	Explanation of need to mobilise/change position Information re use of aids Education
Evaluating/planning care	Information re criteria for evaluating progress Nurse provides assessment of patient/client progress Health promotion
Helping to meet hygiene needs/elimination	Providing information about the process of care as it is delivered Education
Eating drinking	Information/education re diet

ACTIVITY	Dimension of Interest: ELICITING FEEDBACK
GENERAL	**Eliciting feedback from the older person on the effects/effectiveness of care** **Checking that actions taken by the nurse are in accordance with the older person's wishes**
Technical procedure	Checking that procedure is comfortable, that the older person is not anxious or in pain, allowing time for response and checking understanding
Drug administration	Asking older person for feedback on drugs administered, allowing time for response and checking understanding
Helping to mobilise/change position	Checking on comfort during and after procedure
Evaluating/planning care	Asking older person's views on goals/priorities for care
Helping to meet hygiene needs/elimination/dressing	Checking that actions taken during the process of care delivery are appropriate/satisfactory/checking comfort
Eating/drinking	Checking that food/drink is adequate, appropriate to older person's needs

ACTIVITY	**Dimension of Interest: RECIPROCITY**
GENERAL	**Using the older person's name appropriately when speaking to them** **Sharing personal information e.g. about home life** **Appropriate use of humour** **Letting the older person know if they (nurse) has gained from the interaction**
Technical procedure	? use as diversion if pain or distress likely Throughout as appropriate
Drug administration	? use as diversion if pain or distress likely Throughout as appropriate
Helping to mobilise/change position	? use as diversion if pain or distress likely Throughout as appropriate
Evaluating/planning care	Use in assessment to put older person at ease
Helping to meet hygiene needs/elimination	Throughout as appropriate
Eating/drinking	Throughout as appropriate

ACTIVITY	**Dimension of Interest: PRIVACY**
GENERAL	**Drawing curtains prior to administering care of an intimate or personal nature** **Approaching and lowering voice prior to discussing needs/care** **Knocking on door before entering room or requesting permission prior to entering curtains**
Technical procedure	Drawing curtains prior to carrying out procedure or offering to transfer to treatment room. Keeping voice low during procedure
Drug administration	Approaching patient and lowering voice prior to discussing drugs to be given Drawing curtains prior to administering injections
Helping to mobilise/change position	Ensuring that patient is adequately clothed during activity Drawing curtains/closing door as necessary
Evaluating/planning care	Ensuring that any discussion takes place outside of earshot of other patients/staff
Helping to meet hygiene needs	Enabling patient to make use of bathroom (rather than to wash by bed) Drawing curtains completely if washing by bed Making sure that patient is adequately covered during procedure Putting engaged sign on toilet/bathroom door
Eating/drinking	Enabling older person to protect clothing from spillages if necessary Offering choice of place to eat

ACTIVITY	**Dimension of Interest: PARTICIPATION**
GENERAL	**Encouraging the patient to express their needs** **Asking the patient's opinion** **Encouraging the patient to become involved in the processes of care planning and delivery**
Technical care	Encouraging older person to take part as appropriate e.g. holding equipment Encouraging older person comment on procedure e.g. progress of a wound Education in order that a person may self care e.g. intermittent catheterisation.
Drug administration	Take patient's views into account in relation to the administration of scheduled and prn medication Involving patient/encouraging others to involve patient in discussion/decisions about drug regime Encouraging self medication
Helping to mobilise/change position	Including older person in plans for schedule of mobility
Planning/evaluating care	Encouraging patient to identify goals/priorities Encouraging the older person to evaluate their progress in relation to negotiated goals
Helping to meet hygiene needs/elimination	Involving older person/encouraging others to involve in discussion/decisions about plan for meeting hygiene/elimination needs
Eating drinking	Involving older person/encouraging others to involve in discussion/decisions about diet and nutrition

ACTIVITY	Dimension of Interest: INDEPENDENCE
GENERAL	**Encouraging the older person to do as much for themselves as possible**
Technical procedure	?N/A
Drug administration	Self medication Taking drug containers to patient and encouraging self-administration
Helping to mobilise/change position	Encouraging the older person to move with the minimal assistance necessary
Evaluating/planning care	Identifying/negotiating appropriate level of independence in activities of daily living/care activities
Helping to meet hygiene needs/elimination/eating and drinking	Encouraging the older person to complete activities with minimal assistance required

ACTIVITY	**Dimension of Interest: SAFETY**
GENERAL	**Taking appropriate measures to reduce the risk of hazard or injury**
Technical procedure	Use of appropriate technique Ensuring that patient is in a safe position throughout procedure
Drug administration	Checking patient identification band against drug chart Checking drug chart
Helping to mobilise/change position	Providing appropriate aids to mobility. Ensuring brakes are on wheelchair/commode/hoist giving adequate instructions/information while helping to move
Planning/evaluating care	Demonstrating an awareness of the need to minimise risk in planning care
Helping to meet hygiene needs/elimination	Providing appropriate supervision
Eating/drinking	Providing appropriate supervision

APPENDIX IX

Additional tables (Phase III)

Table 8.6 Nurses views on the organisation of nursing care.

	I believe that organising care in this way is						
	Desirable and always possible %	Desirable and sometimes possible %	Desirable but rarely possible %	Not desirable %	Not applicable to my current practice *(please comment)* %	Total %	n
A full assessment is made of patients prior to giving care	37.3	61.0	1.7	0	0	100	59
A written nursing history is taken using a specific form	61.0	32.2	1.7	1.7	3.4	100	59
Written care plans are produced which incorporate patients' needs/problems	81.4	16.9	0	0	0	100	59
Health promotion forms an important goal of care	16.9	49.2	33.9	0	0	100	59
The patient's/client's problems/needs are prioritised	54.2	42.4	3.4	0	0	100	59
Care plans are updated regularly as a basis for care giving	59.3	37.3	3.4	0	0	100	59
Promoting patient autonomy is an important goal of care	34.5	62.1	3.4	0	0	100	58
Written patient goals are used as a basis for evaluating care	42.4	39.0	18.6	0	0	100	59
Patient assessment and care planning is based upon an identified model of nursing	75.9	15.5	5.2	1.7	1.7	100	58
Patient care is organised using a system of primary nursing	37.3	23.7	16.9	5.1	17.0	100	59
Talking to patients as individuals is an important priority of care	76.3	23.7	0	0	0	100	59

Table 8.7 Nurses current practice in relation to dimensions of interest

Practice	Occurrence of practice					
	never %	sometimes %	frequently %	always %	n/a %	to %
Do you offer patients/clients a choice over the time during the day when they have a wash / bath/shower?	3.3	50.8	24.6	19.7	1.6	100
Do you allow patients /clients to determine when their own clothes are changed?	1.7	31.7	33.3	28.3	3.0	100
Before you talk to a relative about a patient do you ask the patients permission?	13.3	51.7	16.7	16.7	1.7	100
Do you encourage male patients/ clients to shave themselves?	0	11.7	35.0	38.3	15.0	100
Do you encourage patients/ clients to plan for the future?	6.9	41.4	27.6	24.1	0	100

	never %	rarely %	sometimes %	often %	n/a %	total %
During conversation with patients /clients are there times when you share aspects of your life?	0	1.6	41.0	57.4	0	100
Within your practice do opportunities arise to educate elderly patients/clients about their health?	1.6	11.5	42.6	44.3	0	100
Do you encourage elderly patients /clients to evaluate their progress?	3.3	13.3	45.0	38.3	0	100
If an older person with whom you are working makes you reel good do you tell them?	1.7	8.5	40.7	49.2	0	100

Table 8.8 Nurses' views on planning care for patients/clients.

Planning activity	Respondents view				
	strongly agree %	agree %	disagree %	strongly disagree %	total
In order for patients/clients to participate in decisions about their care, it is essential that they have the ability to concentrate and remember what they are told.	19.7	34.4	32.8	13.1	100% n = 61
Patients and clients should be allowed to choose ways of behaving/types of care that are not necessarily in line with the views of the health care team.	10.5	73.7	15.8	0	100% n = 57
I prefer to get to know a person gradually because I believe their wishes, problems and needs will become apparent as they come to trust and confide in me.	39.3	57.4	3.3	0	100% n = 61
Patient participation in planning nursing care is only possible if patients/clients have some insight into what is wrong with them.	18.0	55.7	23.0	3.3	100% n = 61
Ensuring that patients /clients comply with medically prescribed care is one of the most important aspects of my job.	6.9	41.4	27.6	24.1	100% n = 58
Participation can take place at many different levels from what to wear, to planning long-term goals of care.	53.3	45.0	1.7	0	100% n = 60
An initial assessment of a persons needs ensures that their wishes are identified.	20.0	38.3	36.7	5.0	100% n = 60
I think its right that people should be protected in certain circumstances from information about their condition.	5.2	46.6	43.1	5.2	100% n = 58
Generally, I understand a persons needs at first assessment.	1.7	40.0	58.3	0	100% n = 60
Involving relatives in care planning often confuses things.	3.3	14.8	68.9	13.1	100% n = 61

Table 8.9 Nurses attitudes/practices in relation to patient participation

	All/most of time %	Some-times %	Rarely or never %	N/A %	Total %	Total n
I ensure that patients/clients attend all meetings at which they are discussed	27.1	42.4	25.4	5.1	100	59
Patients/clients views are taken into account in decision making	67.2	29.5	3.3	0	100	61
I generally ask the person what they understand and how they feel before commencing a procedure.	78.7	21.3	0	0	100	61
I try to ensure that the nurse who knows the patient/client best is present for major procedures or to give detailed information to the patient	44.3	47.5	4.9	3.3	100	61

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Table 8.10 Nurses responses to items on patient-centredness

Patient: ***"I know smoking is bad for me, but I don't seem to be able to stop. Anyway, I don't see that it's any of your business. It's my body that I'm harming, not anyone else's".***

(a)	"I am concerned that if you go on smoking, your health will suffer. You seem to want to stop, but you're not sure how to go about it. Perhaps I can help you? "	**16.7%**
(b)	"You should have more respect for your body. Anyone can stop smoking if they really want to. You're just not trying hard enough".	**0%**
(c)	"I get the feeling that you're worried about your smoking, and that you wish you could stop. Ishare your concern, and I feel that you've got the strength to give up smoking. I would like to help you try"	**21.7%**
(d)	"You're right that its your body that's being harmed, but that doesn't stop me from being concerned for you. I wonder if there is anything I can do to help you stop"	**56.7%**
(e)	"That's not entirely true. Other people breathe in your smoke as well. Perhaps you should think more about them"	**5.0%**
	Total 100%	**n=60**

Patient: ***"I'm in dreadful pain and I know I've only got a few days left to live. If you had any feelings for me, you'd give me something to put me out of my misery"***

(a)	"What makes you think you're going to die? You might have years ahead of you"	**15.5%**
(b)	"It distresses me to think of you in pain like this, and I feel frustrated at being unable to do what you are asking. I believe that you have the right to decide your own fate, and I feel annoyed that the law won't allow me to help you in this way"	**10.3%**
(c)	"I am very upset that you are suffering so much, and I wish there was something I could do. I am very confused about the whole issue of euthanasia, but I can see the sense in what you are saying"	**15.5%**
(d)	"You know I can't do that. As a nurse I have to keep you alive for as long as possible"	**1.7%**
(e)	"You seem to be suggesting that I have no feelings for you. That just isn't true. I'd like to do something to help, but that's just not possible"	**56.9%**
	Total 100%	**n=58**

Patient: ***"These pills are doing me no good at all. You might as well know that for the past three days I have only been pretending to swallow them"***

(a)	"You seem to be worried that these pills are not working, and may even be doing you some harm. It's your decision whether or not to take them, but it might be helpful to discuss your anxieties about them and think about some other options"	**22.0%**
(b)	"You don't think these pills are any good. Would you like to talk to the doctor about them?"	**5.1%**
(c)	"How will you ever get better if you don't follow medical advice? These pills are the best medication for your particular problem. I shall have to tell the doctor that you haven't been taking them"	**0%**
(d)	"That's a really stupid thing to do. When the doctor prescribed those pills, he didn't mean for you to throw them away. Don't you want to get better?"	**1.7%**
(e)	"You are obviously concerned about these pills. Perhaps we could talk about why you feel that way, and maybe get them changed for something different"	**71.2%**
	Total 100%	**n=59**

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APPENDIX IX

Additional tables (Phase III)

Table 8.6 Nurses views on the organisation of nursing care.

	I believe that organising care in this way is						
	Desirable and always possible %	**Desirable and sometimes possible %**	**Desirable but rarely possible %**	**Not desirable %**	**Not applicable to my current practice *(please comment)* %**	**Total %**	**n**
A full assessment is made of patients prior to giving care	37.3	61.0	1.7	0	0	100	59
A written nursing history is taken using a specific form	61.0	32.2	1.7	1.7	3.4	100	59
Written care plans are produced which incorporate patients' needs/problems	81.4	16.9	0	0	0	100	59
Health promotion forms an important goal of care	16.9	49.2	33.9	0	0	100	59
The patient's/client's problems/needs are prioritised	54.2	42.4	3.4	0	0	100	59
Care plans are updated regularly as a basis for care giving	59.3	37.3	3.4	0	0	100	59
Promoting patient autonomy is an important goal of care	34.5	62.1	3.4	0	0	100	58
Written patient goals are used as a basis for evaluating care	42.4	39.0	18.6	0	0	100	59
Patient assessment and care planning is based upon an identified model of nursing	75.9	15.5	5.2	1.7	1.7	100	58
Patient care is organised using a system of primary nursing	37.3	23.7	16.9	5.1	17.0	100	59
Talking to patients as individuals is an important priority of care	76.3	23.7	0	0	0	100	59

Table 8.7 Nurses current practice in relation to dimensions of interest

Practice	Occurrence of practice					
	never %	sometimes %	frequently %	always %	n/a %	to %
Do you offer patients/clients a choice over the time during the day when they have a wash / bath/shower?	3.3	50.8	24.6	19.7	1.6	100
Do you allow patients /clients to determine when their own clothes are changed?	1.7	31.7	33.3	28.3	3.0	100
Before you talk to a relative about a patient do you ask the patients permission?	13.3	51.7	16.7	16.7	1.7	100
Do you encourage male patients/ clients to shave themselves?	0	11.7	35.0	38.3	15.0	100
Do you encourage patients/ clients to plan for the future?	6.9	41.4	27.6	24.1	0	100

	never %	rarely %	sometimes %	often %	n/a %	total %
During conversation with patients /clients are there times when you share aspects of your life?	0	1.6	41.0	57.4	0	100
Within your practice do opportunities arise to educate elderly patients/clients about their health?	1.6	11.5	42.6	44.3	0	100
Do you encourage elderly patients /clients to evaluate their progress?	3.3	13.3	45.0	38.3	0	100
If an older person with whom you are working makes you reel good do you tell them?	1.7	8.5	40.7	49.2	0	100

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Table 8.8 Nurses' views on planning care for patients/clients.

Planning activity	Respondents view				
	strongly agree %	agree %	disagree %	strongly disagree %	total
In order for patients/clients to participate in decisions about their care, it is essential that they have the ability to concentrate and remember what they are told.	19.7	34.4	32.8	13.1	100% n = 61
Patients and clients should be allowed to choose ways of behaving/types of care that are not necessarily in line with the views of the health care team.	10.5	73.7	15.8	0	100% n = 57
I prefer to get to know a person gradually because I believe their wishes, problems and needs will become apparent as they come to trust and confide in me.	39.3	57.4	3.3	0	100% n = 61
Patient participation in planning nursing care is only possible if patients/clients have some insight into what is wrong with them.	18.0	55.7	23.0	3.3	100% n = 61
Ensuring that patients /clients comply with medically prescribed care is one of the most important aspects of my job.	6.9	41.4	27.6	24.1	100% n = 58
Participation can take place at many different levels from what to wear, to planning long-term goals of care.	53.3	45.0	1.7	0	100% n = 60
An initial assessment of a persons needs ensures that their wishes are identified.	20.0	38.3	36.7	5.0	100% n = 60
I think its right that people should be protected in certain circumstances from information about their condition.	5.2	46.6	43.1	5.2	100% n = 58
Generally, I understand a persons needs at first assessment.	1.7	40.0	58.3	0	100% n = 60
Involving relatives in care planning often confuses things.	3.3	14.8	68.9	13.1	100% n = 61

Table 8.9 Nurses attitudes/practices in relation to patient participation

	All/most of time	Some-times	Rarely or never	N/A	Total	
	%	%	%	%	%	n
I ensure that patients/clients attend all meetings at which they are discussed	27.1	42.4	25.4	5.1	100	59
Patients/clients views are taken into account in decision making	67.2	29.5	3.3	0	100	61
I generally ask the person what they understand and how they feel before commencing a procedure.	78.7	21.3	0	0	100	61
I try to ensure that the nurse who knows the patient/client best is present for major procedures or to give detailed information to the patient	44.3	47.5	4.9	3.3	100	61

Table 8.10 Nurses responses to items on patient-centredness

	Patient: ***"I know smoking is bad for me, but I don't seem to be able to stop. Anyway, I don't see that it's any of your business. It's my body that I'm harming, not anyone else's".***	
(a)	"I am concerned that if you go on smoking, your health will suffer. You seem to want to stop, but you're not sure how to go about it. Perhaps I can help you?"	**16.7%**
(b)	"You should have more respect for your body. Anyone can stop smoking if they really want to. You're just not trying hard enough".	**0%**
(c)	"I get the feeling that you're worried about your smoking, and that you wish you could stop. Ishare your concern, and I feel that you've got the strength to give up smoking. I would like to help you try"	**21.7%**
(d)	"You're right that its your body that's being harmed, but that doesn't stop me from being concerned for you. I wonder if there is anything I can do to help you stop"	**56.7%**
(e)	"That's not entirely true. Other people breathe in your smoke as well. Perhaps you should think more about them"	**5.0%**
	Total 100%	**n=60**

	Patient: ***"I'm in dreadful pain and I know I've only got a few days left to live. If you had any feelings for me, you'd give me something to put me out of my misery"***	
(a)	"What makes you think you're going to die? You might have years ahead of you"	**15.5%**
(b)	"It distresses me to think of you in pain like this, and I feel frustrated at being unable to do what you are asking. I believe that you have the right to decide your own fate, and I feel annoyed that the law won't allow me to help you in this way"	**10.3%**
(c)	"I am very upset that you are suffering so much, and I wish there was something I could do. I am very confused about the whole issue of euthanasia, but I can see the sense in what you are saying"	**15.5%**
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	Patient: ***"These pills are doing me no good at all. You might as well know that for the past three days I have only been pretending to swallow them"***	
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(c)	"How will you ever get better if you don't follow medical advice? These pills are the best medication for your particular problem. I shall have to tell the doctor that you haven't been taking them"	**0%**
(d)	"That's a really stupid thing to do. When the doctor prescribed those pills, he didn't mean for you to throw them away. Don't you want to get better?"	**1.7%**
(e)	"You are obviously concerned about these pills. Perhaps we could talk about why you feel that way, and maybe get them changed for something different"	**71.2%**
	Total 100%	**n=59**

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APPENDIX X

Interview Schedules used with Course Members, Managers and Teachers

POST COURSE INTERVIEW (NOMINEE)

Broad issues to be covered

General experiences and perceptions of the programme

What aspects of your practice (if any) do you feel have been affected by the course?

What have you gained from the course? What have you most enjoyed about the course?

What did you least enjoy about the programme?

What was the subject of your written work/project?

Were you able to choose the topic of your written work? How did you decide?

(What critical incidents did you reflect upon for the focus of your essay?)

Were there any topics on the course that you felt were unrelated to your field of practice?

What topics did you find particularly helpful in caring for the older person?

Are there any topics that you would leave out of the programme? Why?

Having completed the course do you feel you would like to pursue further studies?

Do you think the area in which you worked/patients/clients will benefit from what you have learned on the course? In what ways?

Are there any issues that you would have liked to have been included on the course that weren't covered?

Have your colleagues or your manager commented on your practice since completing the course?

POST COURSE INTERVIEW SCHEDULE: MANAGERS

Broad issues to be covered

Have you had any opportunities to discuss the programme with N?

What do you feel (N) has gained from the 941 programme?

Has (N) been able to use what she/he has gained from the course in the clinical setting? In what ways?

Has the course met your needs as the nominating Nurse Manager?

In your view does the 941 programme represent value for money?

To your knowledge, how relevant did (N) find the 941 to their clinical setting?

Have you noticed any changes in (N's) practice since s/he started the programme? (?Obvious links to programme content)

Do you think (N) has developed on a personal level following the 941?

What contact did you have with the School while N was completing the programme?

What follow up has (N) received from the course leader since completing the course?

What are your expectations now that (N) has completed the programme?

Are there any aspects of practice that you are hoping the nominee will change/develop now they have completed the course?

To your knowledge, has (N) experienced any difficulties or frustrations in relation to their practice since starting the programme?

What contact have you had with the School of Nursing since (N) completed the course?

Do you know whether (N)is interested in attending other courses? If yes what sort of course, ENB/diploma/degree?

Do you think completing the 941 will have helped (N's) career prospects? If so, in what ways?

Have you found, that following completion of the 941, nominees wish to continue working in the same field of practice or do they want to move on?

Generally speaking how might the 941 lead to improvements in patient care?

In your view is the structure/length of the course appropriate?

Are there any changes you would like to see in the 941 (examples: course content, length, orientation,tutor support?

Is there anything else that you would like to say about the programme that I haven't covered?

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HIGHLIGHTS

TWENTY-SEVEN

JULY 1997

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Promoting autonomy and independence among older people: an evaluation of educational programmes in nursing

Abstract

This two-year study explored the relationship between the content of educational programmes in nursing and the quality of nursing care for older people, in particular the extent to which nurses promote autonomy and independence for older people in their care. An analysis of curricula for pre- and post-registration educational programmes identified a range of approaches in terms of philosophy, method and content. Outcomes for the ENB Course 941 (Nursing Elderly People) were then investigated in different care settings using an experimental design. Concurrently, a national survey of facilities providing continuing care to older people explored the relationship between the educational preparation of nursing staff and quality of care. These research highlights report the findings from each phase of the study. They will be of particular interest to nurse educators and to nurses and managers working with older people in a wide range of settings.

Method

The research was conducted in three discrete but overlapping phases:

Phase I consisted of a detailed analysis of a national random sample of educational programmes in nursing to identify aspects of the curriculum which relate to the promotion of independence and autonomy among older clients and patients. The sample included common foundation programmes and branches, including degree programmes, post-registration preparation for community practice and programmes focusing specifically on the needs of older people such as the ENB 941 and 298. Methods included a self-completion questionnaire sent to programme leaders (n=77) and a content analysis of curriculum documents (n=69).

The second phase involved a survey of nursing homes in three NHS Executive Health Regions to investigate the relationship between the educational preparation of staff and resident autonomy and choice (n=660). Resident autonomy was measured using an 18 item scale completed by the senior nurse within each home (Challiner et al. 1994). A composite educational score was based upon the proportion of staff within each facility with different levels of qualification. This allowed us to explore associations between the educational preparation of staff and autonomy of residents.

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The final phase of the study used a quasi-experimental design to determine the effects of the ENB Course 941 (Nursing Elderly People) on the knowledge, attitudes and observed practice of nurses in a range of care settings. These data were complemented by semi-structured interviews with course members, colleagues and course teachers following completion of the programme (n=43).

Main Findings

A review of the literature revealed important gaps in knowledge in relation to the extent to which autonomy and independence are important goals of care for **all** older people. Nonetheless the review identified evidence of the positive effects for older people of a number of nursing interventions and strategies aimed at promoting personal autonomy and functional independence (Box 1). The outcomes of these interventions for older people include higher levels of satisfaction with care, decreased physical dependency and a greater personal sense of control.

Box 1 Nursing interventions for promoting personal autonomy and independence for older people

- offering the older person choice in relation to day-to-day activities
- providing information or explanation about care
- eliciting feedback from the older person in relation to actions taken or care given
- protecting and respecting the patient's privacy
- promoting independence in the activities of daily living
- encouraging participation in care planning
- demonstrating the reciprocity of the nurse-patient relationship

Findings from the survey of educational programmes:

- Analysis of course curricula revealed content relating to most of the dimensions of autonomy and independence within most programmes. Exceptions were the notion of working in partnership with patients and clients and the management of risk. Although participation in care features as a key value within many course philosophies, this is often not made explicit in the course content. Where risk is mentioned, this is generally not specifically related to decision-making about the need to balance an older person's autonomy with an acceptable degree of risk.
- We found incoherence and illogical structure in some curriculum documents, with no clear relationship between course philosophy, objectives and content. For some documents, language was obscure and convoluted. There was a lack of any consistent pattern in relation to the notions of autonomy and independence within curriculum documents. Apart from the focused courses (ENB 941 and 298), few curricula identify the dimensions of interest applied to older people as specific content. Rather the dimensions form 'threads' throughout the curriculum, without explicit reference to how course members might be encouraged to apply these ideas when caring for older people.
- We found very little evidence that older people are involved in the development and delivery of educational programmes. Where this does happen, it is generally through advocates and special interest groups rather than service users themselves. Only one programme in the sample involved patients and clients in student assessment. Although it appears that practitioners are given opportunities to participate in programme development and delivery, many course leaders identified barriers to collaboration, such as pressures of work and the speed at which curricula need to be developed.
- Course leaders were keen to make the programmes more practice focused and to strengthen the links between theory and practice, e.g. by conducting more tutorials in clinical practice settings.
- Those programmes which appeared to focus more explicitly upon the needs of older people for self-determination shared the following characteristics:

an emphasis on challenging attitudes and stereotypes,

content specifically aimed at developing the skills to challenge and change practice,

a consistent emphasis upon participation throughout the curriculum.

These characteristics were most apparent in the mental health programmes (pre-registration mental health branch and ENB 812), reflecting the emphasis on the development of advanced interpersonal skills.

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- **Use of the phrase 'the elderly' is common within curricula. This phrase may have** negative connotations and is disliked by many older people themselves (see e.g. Walker 1993). A number of documents also suggested a gender bias. There is a need to ensure that terminology within curriculum documentation is non-ageist and non-sexist.

Findings from the survey of nursing homes:

- There was wide variation in the proportion of staff with a range of pre- and post-registration educational qualifications. At the time of the study, less than a quarter of staff were undertaking any form of continuing professional education within the majority of nursing homes.
- Most nursing homes appear to have little contact with nursing educational centres and it is possible that information on educational programmes and events is not readily available. Only one-third of homes currently provide placements for nursing students. This may be significant in that a number of studies have demonstrated the importance of responsibilities for student preparation in motivating qualified nurses to seek opportunities for continuing professional education (Hallett et al, 1992; White et al, 1994; Thomson et al, 1995).
- Resident autonomy scores in our large sample of nursing homes were higher than that found in previous research (Challiner et al, 1994), suggesting a trend of improvement in the quality of nursing home care.
- Resident autonomy was positively associated with:
  - the overall level of nurses' educational experience
  - the proportion of qualified staff undertaking educational programmes
  - the level of contact with nursing educational centres.

Findings from the evaluation of the ENB Course 941 (Nursing Elderly People):

- Observation of thirty nurses in a range of care settings and ratings of care events revealed wide variation in the extent to which individual nurses demonstrate an awareness of strategies for promoting autonomy and independence within their practice. While most nurses incorporate **some degree of information-giving and attempts to gain feedback into their day-to-day practice with older people,** they appear to be less skilled at involving patients and clients in decisions about their plan of care.
- Consistently high scores in relation to strategies to promote patient safety suggest that nurses find it difficult to determine an appropriate degree of risk and may unwittingly be threatening the personal autonomy of older patients and clients as a consequence. This finding reflects the analysis of course curricula in Phase I of the study which suggested that the issues of patient participation and risk-taking are insufficiently covered within most programmes.
- Interviews with course members and their managers in three educational centres suggested that the ENB course 941 is very successful in challenging stereotypical views of older people. The programme caused most participants to reflect both on their own practice and that of their colleagues. Some participants developed the confidence to challenge what they viewed as unacceptable practice or the expression of ageist views by others. Students appreciated the diversity of teaching methods within the programmes and the opportunities to learn from each other.
- Comparison of pre- and post-course ratings of practice failed to detect a significant statistical difference on the dimensions of interest between the nurses who had completed the ENB course 941 and the matched controls. There were however higher mean scores on most of the dimensions of interest for the intervention group than for the control subjects.
- Some managers and course members identified changes in nursing practice which they attributed directly to the ENB Course 941. These resulted mainly from the implementation of project work completed during the programme.
- All participants identified barriers to improving care through changes in practice which may have limited the effects of the educational programme. These included the attitudes of other staff, in particular a resistance to change, and staff motivation in the context of major changes in service provision and, for some, the threat of redundancy. Some participants questioned

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the extent to which the programme prepared them to initiate and manage change, particularly since many nominees were 'junior' members of nursing teams.

- Some course members and managers were concerned about the relevance of the ENB Course 941 to their own practice setting, and identified a need for more specialist and advanced courses on specific aspects of practice with older people, rehabilitation for example. A substantial minority of course members believed that the programme did not adequately cover the needs of older people with mental health problems. These findings suggest a need for nurse-educators to work closely with service providers in order to negotiate the most appropriate educational provision.
- There was a tendency for nurse educators to focus upon abstract concepts and theoretical ideas in their teaching at the expense of practical suggestions for applying such knowledge. There is an urgent need for nurse educators to introduce practical examples of ways in which the broad aims of promoting autonomy and independence for older people can be realised. We suggest that some of the examples described in the observational field-notes for this study and included in the full report could be developed into teaching materials for this purpose.
- It was not possible to conduct a randomised controlled trial as originally intended in this study. A quasi-experimental design with matched controls appears to be a practical alternative but requires a multi-centre study and a timescale which will allow the generation of a sufficiently large sample, to be confident of detecting the effects of an educational intervention.

Further information

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Details about the project

In July 1994, the English National Board for Nursing, Midwifery and Health Visiting (ENB) commissioned a multi-disciplinary research team at the University of Sheffield to undertake a two-year study to evaluate programmes of nurse education for the care of older people. The main aim of the study was to determine the extent to which pre- and post-registration educational programmes in nursing prepare nurses to promote patient/client autonomy when providing care for older people. A three-phase design has allowed the project team to make recommendations about the identification of educational needs, the development of educational programmes for the care of older people and the development of links between educational centres and practice settings. The research also raised questions about the most appropriate methods for evaluating educational programmes in nursing. The Final Report includes detailed descriptions of nursing practice in relation to the promotion of autonomy and independence of older people, relevant to all nurses working with older people in whatever setting. The report will also be of interest to those in higher education with responsibility for planning and teaching curricula relating to the care of older people.

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